COACHCARE | SERVICE LINE STRATEGY

Clinical Neurology Specialists

An independent, physician-owned adult neurology practice in Las Vegas and Henderson, Nevada: two offices, five board-certified neurologists and four advanced practice providers, AANEM-accredited electrodiagnostic labs, and a multi-chronic Medicare panel

Remote Care Service Line Optimization Report

October 2026

Principal Care Management for the neurological conditions the practice treats, billed under the CY2026 rules at Nevada amounts, run inside Greenway Intergy, staffed by CoachCare and owned by the practice

Purpose of this document

Prepared by CoachCare, October 2026, as a discussion document for the leadership and billing team of Clinical Neurology Specialists. It sets out the shape of the practice's Medicare panel as the CY2024 claims files show it, the Medicare program that pays a neurology practice to manage a complex condition between visits, how that program would run inside Greenway Intergy, how it answers the supervision, documentation, fee and coinsurance questions a healthcare attorney asks, and a 24-month financial forecast priced at the practice's own Medicare locality.

The argument is short. The practice diagnoses and treats chronic neurological disease in a panel that is older and multi-chronic. Most of what follows a diagnosis happens between appointments, and Medicare pays for that work every month through Principal Care Management. At CNS it is not yet billed as a program. This report shows what that program returns, who does the work, and how it starts without capital or a hire.

Prepared by CoachCare for discussion with Clinical Neurology Specialists. © 2026 CoachCare.

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Executive Summary

Clinical Neurology Specialists (CNS) is a physician-owned, independent adult neurology practice founded in 1998, with offices in Las Vegas and Henderson. Five board-certified neurologists and four advanced practice providers see patients across both. The practice runs AANEM-accredited electrodiagnostic labs in each office and a full in-office testing menu, and its subspecialty programs cover epilepsy, movement disorders, multiple sclerosis, memory care and headache medicine. Two decades of patient history sit in one Greenway Intergy record.[1]

The CY2024 Medicare claims for the practice's neurologists describe a panel whose neurological conditions are hard to manage alone: an average age of 73, an average risk score of 1.26 against a national 1.00, and **hypertension in three in four beneficiaries or more, diabetes in 37%, ischemic heart disease in 32%, chronic kidney disease in 25% and depression in 25%**, alongside the stroke, dementia and Parkinson's diagnoses the practice treats. The neurologists billed 22 distinct services that year, visits and in-office diagnostics, and no principal care management or other care-management program appears at meaningful scale. The forecast in Section 6 covers 2,000 active Medicare patients, the practice's own working figure.[2]

The observation this report is built on

The diagnosis comes first. The months between visits come next.

CNS built its name on getting the diagnosis right. What follows a diagnosis of epilepsy, Parkinson's disease, multiple sclerosis, dementia or chronic migraine mostly happens between appointments: the missed dose, the fall, the new symptom, the caregiver who needs a call back. Medicare pays for that work through Principal Care Management (PCM), a monthly service built for the specialist who manages one complex condition. The service line in this report is that work, run as a program, staffed by a partner, supervised by the practice's clinicians and billed under Clinical Neurology Specialists.

What the Value Analysis returns

	Year 1	Year 2	24 months
Net reimbursement	**$283,902**	**$524,893**	**$808,796**
CoachCare fees	$158,649	$274,788	$433,438
Net to the practice	**$125,253**	**$250,105**	**$375,358**
Practice margin	44.1%	47.6%	**46.4%**

CoachCare Value Analysis: 2,000 active Medicare patients in scope, Principal Care Management, enrollment through the referrals of 9 neurologists and APPs, half of patient coinsurance collected, CY2026 fee schedule at the Nevada locality amounts. Margin is net to the practice divided by net reimbursement.

One market fact sits under every number above. Medicare Advantage covers 56.76% of Clark County's Medicare beneficiaries. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast prices every patient in scope at the Medicare fee schedule.[3]

[1] cnsnevada.com about, locations, treatments and diagnostic-testing pages, retrieved October 2026: founded 1998; "physician-owned and independent"; five board-certified neurologists and four advanced practice providers (one APRN, three PA-C); AANEM-accredited electrodiagnostic labs at both offices. Greenway patient portal; Greenway Intergy confirmed by the practice.

[2] CMS Medicare Physician & Other Practitioners by Provider, CY2024, the practice's neurologists billing at its two addresses: average age 73; weighted HCC risk score 1.26; beneficiary-weighted prevalence hypertension 75%, hyperlipidemia 75% (CMS publishes 75% or more as 75%), diabetes 36.8%, ischemic heart disease 32.0%, chronic kidney disease 24.8%, depression 24.6%, stroke or TIA 17.0%, dementia 9.4%, Parkinson's disease 5.8%. By Provider and Service, CY2024: 22 distinct HCPCS codes.

[3] CMS Medicare Advantage State/County Penetration, October 2026: Clark County, Nevada, 431,433 eligibles, 244,878 enrolled, 56.76%.

1. **Referrals set the pace.** The program is built on the clinicians' own referrals. The neurologist's or APP's part is a flag in Intergy at the visit, when the diagnosis and the plan are fresh; CoachCare's team calls each referral within days. With all nine clinicians referring about 8 patients a month, the eligible pool of 510 patients fills in month 11. At 10 referrals a clinician it fills by month 9 and the practice nets $394,861; at 6 it takes until month 14 and nets $343,157.
2. **The service line is positive from month 2.** Month 1 nets −$4,439 on 18 patients, because the one-time implementation and Intergy setup charges post ahead of the ramp. Month 2 nets $1,658, and the program holds $20,842 a month to the practice from month 12.
3. **The panel sets the ceiling.** A larger count of active Medicare patients is what raises the 510-patient pool: at 3,000 the program returns $492,686 to the practice over 24 months; at 4,000, $560,200. With a larger count, referral pace decides most of the two years: a 3,000-patient pool takes until month 16 to fill and a 4,000-patient pool until month 21. The Intergy count is discovery item number one.
4. **Nobody at the practice is hired.** CoachCare delivers 9,902 care-team hours over 24 months, about 4.8 full-time-equivalent years. The care managers and the enrollment outreach team are CoachCare's payroll, embedded in the fee. The nine clinicians refer and supervise; the practice's own billers file the claims.
5. **PCM is built for the specialist.** It pays for one complex condition on a disease-specific plan the neurologist owns, which is what epilepsy, Parkinson's disease, multiple sclerosis, dementia and chronic migraine need between visits. Section 2.2 explains the choice of program.
6. **Flat fees, no lock-in, and profitable at any collection rate.** CoachCare charges $30 for the first 30 minutes of care in a month and $26 for each additional 30, with no per-patient platform fee and never a percentage of what the practice bills or collects, on a one-year agreement with 90 days' notice to end it. If the practice collects none of the patient's 20% share, the program still returns $285,491 over 24 months at a 39.7% margin.
7. **The attorney's question has an answer in the regulation's text.** Medicare's definition of the staff who may furnish this work covers independent contractors and the companies that employ them, and PCM's clinical-staff time runs under general supervision. The claims go out under the practice's own enrollment. Section 5 sets out the citations.
8. **The program lives in Greenway Intergy.** CoachCare is the care-coordination integration Greenway itself offers Intergy practices. Enrollment is a flag and a signed note; charges and a monthly care summary come back into the chart. The setup is $2,500 one time, with no monthly or per-patient integration fee.
9. **The CY2027 proposed rule barely touches this line.** Repriced at the proposed Nevada amounts, the 24-month PCM line falls by $3,775, 0.47%. Section 8 draws it to scale.

1. The Practice and the Panel

1.1 Two offices, nine clinicians

Clinical Neurology Specialists treats adults only. It does not operate, and it describes itself as physician-owned and independent. Its clinicians work across both offices, and both offices share the same patient record, so a patient can be enrolled at whichever office they visit.[4]

Office	Clark County address	What it means for this program
Las Vegas	7751 W. Flamingo Rd, Suite A-100, Las Vegas, NV 89147	A full diagnostic office and a referral point: every visit is a chance to flag an eligible patient
Henderson	1691 W. Horizon Ridge Pkwy, Suite 100, Henderson, NV 89012	The same services and the same record; the same protocols, flags and escalation routes from the first week

[4] cnsnevada.com about, locations, office and faqs pages, retrieved October 2026: adult patients only; no surgery; clinicians work across both sites; both offices share the same patient records.

The five board-certified neurologists and four advanced practice providers (one APRN and three PA-Cs) are the program's nine referring clinicians, and the program is built on their referrals: a flag in Intergy at the visit is the whole enrollment step for the clinician. The neurologists own the care plans for the patients they refer. The subspecialty depth is what makes a neurology panel a strong fit for monthly care management. The practice offers fellowship-trained epilepsy care with VNS and DBS device management, a movement disorders program, multiple sclerosis care with an MS-certified nurse, memory evaluations at an active Alzheimer's research site, and headache medicine with Botox and CGRP therapy. The electrodiagnostic labs in both offices are AANEM-accredited, and the in-office menu runs from EMG and nerve conduction studies to routine and ambulatory EEG, evoked potentials, transcranial Doppler and VNG. Each subspecialty is a condition with a care plan that changes between visits, and Section 3.1 turns each one into a monthly pathway.

1.2 What the CY2024 claims say

The CY2024 Medicare by-provider and by-provider-and-service files were queried for the neurologists billing at the practice's two addresses. The profile below is the Original Medicare population they saw that year. It describes the panel's shape. It is not the panel's size: it leaves out Medicare Advantage members, the advanced practice providers and any clinician whose claims carry another address.[5]

CY2024 Medicare fee-for-service, the practice's neurologists	Value
Beneficiaries, counted once per neurologist seen	**2,356**
Medicare allowed amount	$1,067,157
Dual-eligible beneficiaries	383
Average beneficiary age	**73**
Weighted risk score (national average 1.00)	**1.26**
Distinct services billed	22, visits and in-office diagnostics
Principal care management or other care management	no program at meaningful scale
Hypertension and hyperlipidemia	**Each in three in four beneficiaries or more**
Condition prevalence, in full	Figure 1

CMS Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024. CMS publishes any prevalence of 75% or more as 75%, and suppresses provider-and-code lines under 11 beneficiaries. Prevalence is weighted by beneficiaries.

[5] CMS Medicare Physician & Other Practitioners by Provider (dataset 8889d81e-2ee7-448f-8713-f071038289b5) and by Provider and Service (dataset 92396110-2aed-4d63-a6a2-5d6207d46a29), CY2024 vintage, retrieved October 2026, for the neurologists whose CY2024 claims carry the practice's addresses: 2,356 beneficiary-neurologist pairs; $1,067,157 allowed; 383 dual-eligible. Advanced practice providers show no CY2024 row.

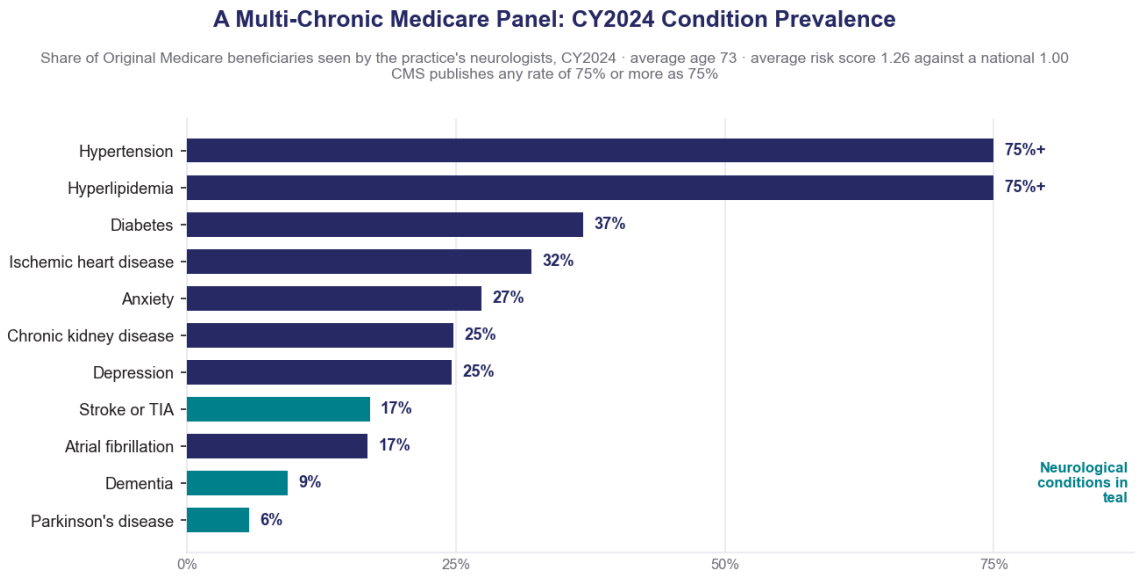


Figure 1 — CY2024 condition prevalence among the Original Medicare beneficiaries the practice's neurologists saw, with the neurological diagnoses in teal. Hypertension and hyperlipidemia sit at the CMS top-code of 75%.

Read the figure and the table together. The figure is the clinical case: an older panel where three in four beneficiaries or more carry hypertension, more than a third are diabetic, a third have ischemic heart disease and a quarter have kidney disease or depression, on top of the neurological diagnosis that brought them to the practice. PCM pays for one complex condition that needs a disease-specific plan, and one of the ways CMS describes that complexity is a condition whose management is unusually complex because of comorbidities. Epilepsy, Parkinson's disease, multiple sclerosis, dementia and chronic migraine on this panel fit that description.

The table is the billing around that panel. The neurologists billed visits and diagnostics; **no principal care management or other care-management program shows up at meaningful scale in the CY2024 claims**. The conditions are in the chart. The monthly management of them is not yet billed.[6]

1.3 The market and the rate basis

Both offices are in Clark County, which had 431,433 Medicare eligibles in October 2026, 244,878 of them in a Medicare Advantage plan: **56.76% Medicare Advantage**, against 57.02% in July. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The forecast in Section 6 prices every patient in scope at the Medicare fee schedule. Which plans hold the practice's Medicare patients, and how each one pays for PCM, is the second thing to confirm after the patient count.[7]

The rate basis follows the geography. Nevada is a single statewide Medicare locality, locality 00 under the Noridian JF contractor, and it covers both offices. 99426 pays $67.45 and 99427 pays $53.86 at the CY2026 non-facility amounts. Both offices bill as an office setting, so every dollar in this report is priced at the non-facility amounts for Nevada.[8]

[6] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024: no principal care management (99424 to 99427) or other care-management line for any of the practice's neurologists. CMS suppresses provider-and-code lines under 11 beneficiaries, so the supportable statement is no program at meaningful scale.

[7] CMS Medicare Advantage State/County Penetration, October 2026 (ma-state-county-penetration-october-2026.zip): Clark County 431,433 eligibles, 244,878 enrolled, 56.76%. July 2026: 428,170 eligibles, 244,131 enrolled, 57.02%.

[8] CY2026 Medicare Physician Fee Schedule, non-facility amounts, Noridian JF carrier 01312, locality 00 (Nevada, statewide); geographic indices work 1.000, practice expense 1.001, malpractice 0.833; conversion factor $33.4009: 99426 $67.45; 99427 $53.86. National non-facility: 99426 $67.80; 99427 $54.11.

2. Principal Care Management for a Neurology Panel

2.1 What PCM pays for, and who qualifies

Principal Care Management pays for clinical-staff time spent between visits on one complex chronic condition: care planning, medication management, coordination with other physicians and calls with the patient or caregiver. 99426 pays for the first 30 minutes of clinical-staff time in a calendar month and 99427 for each additional 30 minutes. Time under 30 minutes in a month is not billable, so the care team plans each month to clear it.[9]

What CMS requires	How it reads on a neurology panel
One complex chronic condition expected to last at least three months, at significant risk of acute exacerbation, decline or death	Epilepsy, Parkinson's disease and tremor, multiple sclerosis, dementia, chronic migraine, neuropathy, myasthenia gravis, and secondary stroke prevention
A disease-specific care plan that needs developing, monitoring or revising	The neurologist owns the plan for the one condition; the care team keeps it current as encounters close
Frequent medication adjustments, or management made unusually complex by comorbidities	Antiseizure and dopaminergic dosing, disease-modifying therapy, preventive migraine therapy, on a panel where most patients carry two or more other chronic conditions
Ongoing communication and care coordination between the practitioners involved	Refills, referrals, therapy and infusion scheduling, and the patient's other physicians kept informed

CMS MLN909188 (June 2025); CY2022 Physician Fee Schedule final rule, CPT 99426 and 99427 and the PCM descriptor elements.

Enrollment starts from a visit with the billing practitioner when the patient is new or has not been seen within a year. The practitioner orders the service, and the patient consents, verbally or in writing, after hearing what the program is, that a monthly share of the cost may apply and that they can stop at any time. Section 5.4 covers consent in detail.

2.2 Why PCM rather than CCM

Medicare's other monthly care-management service, chronic care management (CCM), is already crowded in this market. Clark County practices billed Original Medicare for **116,192 CCM services and 5,694 PCM services in 2024**, mostly from primary care and cardiology, and only one practitioner can bill CCM for a patient in a month. Many of the practice's patients may already be in a primary care physician's or cardiologist's CCM program.[10]

[9] CMS MLN909188, June 2025: PCM services "focus on a single, high-risk chronic condition expected to last at least 3 months"; time under 30 minutes in a calendar month is not billable. CY2022 Physician Fee Schedule final rule, 86 FR 65117 (CPT 99426 and 99427 for clinical-staff time) and 86 FR 65275 (descriptor elements: a disease-specific care plan; frequent medication adjustments or management unusually complex due to comorbidities; ongoing communication and care coordination).

[10] CMS Medicare Physician & Other Practitioners by Provider and Service, CY2024, Clark County providers, CCM codes 99490, 99439, 99487, 99489, 99491 and 99437 against PCM codes 99424 to 99427. Cardiology and internal medicine lead CCM by specialty. MLN909188: "only 1 practitioner can provide and bill CCM services during a calendar month."

The rule, as CMS states it

The same practitioner cannot bill CCM and PCM for one patient in one month. However, CMS says it is allowable "for a primary care practitioner to offer CCM and a specialist to offer PCM" for the same patient, provided the conditions addressed are different, with two care plans.[11]

So PCM never collides with a referring physician's program. It keeps the practice's service line clear of every primary care and cardiology program its patients may already be in, and it keeps the neurologist's plan on the condition the practice treats.

3. The Service Line

A named PCM service line with its own P&L and monthly scorecard, run inside Greenway Intergy. Clinical Neurology Specialists owns the program, its protocols, its patients and its revenue. CoachCare's care team does the monthly work under the general supervision of the practice's clinicians, using a care pathway built around each condition.

3.1 Condition care pathways

PCM pathway	What the care team works on each month
Epilepsy	Seizure log and trigger review, medication adherence and refill gaps, side effects, the rescue-medication plan, and VNS follow-up kept on schedule
Parkinson's disease and tremor	Dose timing against symptoms, a fall screen every month, swallowing and mood checks, and therapy referrals tracked to completion
Multiple sclerosis	Disease-modifying therapy adherence, infusion and lab scheduling, and new or worsening symptoms routed to the practice's MS nurse
Memory loss and dementia	Calls that include the caregiver, home-safety and wandering screens, behavioral symptoms escalated early, and advance-care-planning prompts
Headache and migraine	Headache days tracked against the preventive plan, the Botox and CGRP schedule kept, and medication overuse caught before the next visit
Stroke and TIA	Secondary stroke prevention between visits: antithrombotic and statin adherence, blood pressure follow-up with the patient's other physicians, and new deficits escalated the same day
Neuropathy and myasthenia gravis	Symptom change and weakness checks, medication dosing and side effects, falls, and the next test or infusion booked

The practice's clinicians review and sign off on every pathway before launch.

3.2 The monthly cadence and escalation

Step	What happens
Refer	The neurologist or APP flags an eligible patient in Intergy at the visit, when the diagnosis and the plan are fresh
Enroll	CoachCare's enrollment outreach team calls each referral within days, captures and files consent, and explains the program in plain language, including the patient's share of the cost
Plan	A disease-specific care plan for the patient's principal neurological condition, built from the chart and kept current as encounters close in Intergy; reviewed at least once a year

[11] CMS Chronic Care Management Frequently Asked Questions, citing the CY2020 Physician Fee Schedule final rule, 84 FR 62697: "CCM and PCM cannot be billed by the same practitioner for the same patient in the same month. However, it is allowable, for instance, for a primary care practitioner to offer CCM and a specialist to offer PCM (or vice versa, as appropriate). The conditions being addressed by CCM and PCM must be different. If CCM and PCM are provided concurrently, two care plans would be required."

Step	What happens
Call	Monthly outreach by phone on business days, Monday through Friday, 8 AM to 5 PM in the patient's time zone: medication, symptoms, appointments, referrals, caregiver questions. At least 30 minutes of clinical-staff time in every billed month
Escalate	Anything a neurologist needs to see goes to a named team member at the office, by the route the office chooses. Concerning symptoms from the last 72 hours go the same way the same day
Document	Every call, attempt and escalation is logged by staff member and date, and a monthly care summary posts to the chart

The emergent floor, stated plainly

Triggers. Stroke signs (confusion, slurred speech, sudden numbness or weakness on one side), the worst headache of a patient's life, fainting or near-fainting, chest pain, new shortness of breath, or vision loss reported during a call.

Action. 911 is called with the patient still on the line, then the office is notified the same day. If the patient refuses, the care manager calls the office with the patient still on the line; if the office cannot be reached, CoachCare calls 911 anyway.

The floor. CoachCare's emergent policy overrides any office-specific preference. The practice shapes the routing for everything else. Patients are told at enrollment to call 911 in an emergency, and to follow the practice's usual after-hours instructions for anything urgent outside the care team's hours.

3.3 Who carries the work, and who owns it

Function	CoachCare	Clinical Neurology Specialists
Referral and enrollment	The enrollment outreach team calls every referral within days, captures consent and follows up by phone; CoachCare's payroll	**Nine neurologists and APPs flag eligible patients in Intergy at the visit**
Care management	Care managers at about 160 patients each; care plans, monthly calls, escalation and documentation	**Sets the protocols, signs the care plans, makes every clinical decision**
Billing	Time logged by staff member and date; charges prepared in Intergy for the practice's billers	**Reviews and files the claims under its own enrollment; keeps the revenue**
Account	A dedicated customer success advisor reviews the service line's P&L with the practice every month: billed, paid, denied, and the margin against this forecast	A named program lead; a standing monthly review
Patient materials	Brochures, exam-room posters and waiting-room screen content in the practice's own branding, supplied as part of onboarding	Approves the materials and the consent language

The ownership rule. This is the practice's service line. CoachCare supplies the care team, the platform and the billing preparation. The practice's clinicians set the protocols, sign the care plans and make every clinical decision, and the claims go out under Clinical Neurology Specialists. The agreement runs one year, either side can end it on 90 days' notice, and the practice can tell CoachCare to unenroll any patient at any time.

3.4 The PCM codes and CoachCare's fees

Code	What it pays for	Medicare, CY2026 Nevada	CoachCare fee
99426	Principal care management, first 30 minutes of clinical-staff time in a calendar month	**$67.45**	**$30**
99427	Each additional 30 minutes in the same month	**$53.86**	**$26**

Code	What it pays for	Medicare, CY2026 Nevada	CoachCare fee
	Per-patient platform fee		**None**

CY2026 Medicare Physician Fee Schedule, non-facility amounts, Noridian JF, Nevada locality 00, which covers both offices. These are the amounts the Value Analysis is priced on. CoachCare charges per completed 30-minute block of care.

Medicare Advantage

About 57% of Clark County's Medicare beneficiaries are in a Medicare Advantage plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The plan-by-plan read is item four on the confirmation list in Section 9.3.

4. Greenway Intergy Integration

CoachCare is the care-coordination integration Greenway itself offers to Intergy practices. Greenway's own overview of it lists bidirectional enrollment by service, automated claim generation, compliance documentation with an integrated care summary, escalation tasks and exchange of health history, all inside the Intergy workflow. For CNS that means the program runs in the record the practice has used for two decades, with the patient portal it already has.[12]

Step	What happens in Intergy	Who does it
Flag	A clinician marks a patient enrolled, declined or opted out with an Intergy flag and signs the note. No referral fax and no separate portal	Any of the nine clinicians, at the visit
Record	Demographics, the problem list with the ICD-10 codes the billing team maintains, medications, history and recent encounter notes flow to the care team, including the free-text notes the neurologists dictate. Nobody re-keys a note	The integration
Update	Every closed encounter sends an updated record, so the care plan keeps pace with the chart	The integration
Charges	Charges come back into Intergy by about the fifth business day of the following month and go through the review the practice's billers already run	CoachCare prepares; the practice's billers review and file
Summary	A monthly care summary for every enrolled patient posts to the chart a day or two after the charges, as the documentation behind the claim	CoachCare
Tasks	Escalations and enrollment status arrive as Intergy tasks routed to the team member each office names	CoachCare sends; the office acts

The Intergy setup is $2,500 one time, with no monthly or per-patient integration fee. It runs alongside onboarding and staff training, so the integration does not hold up the first enrollments.

5. Compliance and Audit Readiness

A healthcare attorney reviewing a care-management partner asks four questions: who furnishes the service and under whose supervision, what proves it happened, how the partner is paid, and what happens to the patient's share. This section answers each one from the primary sources.

[12] Greenway Health, Greenway Intergy Integration overview (2024): Greenway Care Coordination Services use the integrated CoachCare platform; areas of focus are bidirectional enrollment by services, automated claim generation, compliance documentation and integrated care summary, escalation tasks and exchange of health history. Charges by about business day five and the monthly summary posted to the chart per CoachCare's Intergy workflow.

5.1 Supervision: who does the work, under whose authority

Medicare lets the clinical-staff time in Principal Care Management be furnished under the billing practitioner's **general supervision**, which means under the practitioner's overall direction and control without the practitioner being on site. Its regulation defines the staff who may furnish that time, auxiliary personnel, "regardless of whether the individual is an employee, leased employee, or independent contractor" of the practitioner, and defines an independent contractor to include "an entity that has hired such an individual". The same definition carries two conditions on the individual: no exclusion from federal health programs, and any licensure the State requires for the service. Only the supervising practitioner bills.[13]

CMS put PCM's clinical-staff time on the general-supervision list when it created the service, and its care-management guidance names an outside case management company as an acceptable source of clinical-staff time when the incident-to and other billing rules are met.[14]

What Medicare asks	Where it says so	How this program meets it
The billing practitioner stays involved	CY2017 fee schedule rule, on care-management services: ongoing oversight, management, collaboration and reassessment; a third party without clinical integration is not furnishing the service	Clinicians order the service, sign the care plan and pathway, receive escalations and review the monthly summary in the chart
Clinical integration with the practice	Same rule; CMS care-management guidance	The care team works from the Intergy record and writes back to it; nothing lives only in a vendor system
Practitioner oversight is not delegated	CMS care-management guidance: the service cannot be completely delegated to clinical staff	The care team carries the staff time; the practice's clinicians keep the oversight
The supervising practitioner bills	42 CFR 410.26(b)(5)	Claims go out under the practice's own enrollment, prepared for its billers

42 CFR 410.26(a)(1), (a)(3), (a)(4) and (b)(5); CY2017 Physician Fee Schedule final rule, 81 FR 80249; CY2020 Physician Fee Schedule final rule, 84 FR 62696; CMS Chronic Care Management FAQs.

5.2 Documentation: what proves it happened

- **Consent, before the first billed month.** Captured verbally or in writing, with the required elements, and filed in the chart.
- **The care plan, in the chart.** Disease-specific for the principal condition, updated as encounters close and reviewed at least once a year.
- **Time, logged by person and date.** Every minute that counts toward a code is logged by staff member, date and activity, so a 99426 or a 99427 can be traced to the work behind it.
- **A monthly care summary beside the charge.** Every enrolled patient's month is summarized and posted to Intergy next to the claim it supports.
- **Escalations, closed out.** Each one records the symptom or finding, the route, the person reached, the outcome and the follow-up.

[13] 42 CFR 410.26 (eCFR, current text, amended through 91 FR 12079, March 12, 2026). (a)(1) auxiliary personnel, "regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner)", not excluded by the OIG, meeting State requirements including licensure; (a)(3) general supervision, "overall direction and control", presence not required; (a)(4) independent contractor, "an individual (or an entity that has hired such an individual)" receiving an IRS-1099; (b)(5) designated care management services under general supervision, and "only the supervising physician (or other practitioner) may bill Medicare for incident to services."

[14] CY2020 Physician Fee Schedule final rule, 84 FR 62696: PCM clinical-staff time (then G2065, now 99426 and 99427) added to the designated care management services furnished under general supervision under 410.26(b)(5). CMS Chronic Care Management Frequently Asked Questions (updated August 16, 2022): the clinical-staff portion may be provided "by clinical staff external to the practice (such as by a case management company)" if the incident-to and other billing rules are met.

The evidence sits in the practice's own chart, where an auditor would look, rather than in a vendor portal that has to be requested. For a practice that wants every Medicare claim provable, the paper trail is built as the work happens rather than assembled after a request arrives.

5.3 Fees: how CoachCare is paid

CoachCare charges a flat fee per completed 30-minute block of care: $30 for the first 30 minutes in a month and $26 for each additional 30, with no per-patient platform fee. The only other charges are implementation and the Intergy setup, both one time, and a small fee per new enrollment. Fees are never a percentage of what the practice bills or collects, and they do not move with the practice's collections or with Medicare's payment. The HHS Office of Inspector General has long flagged percentage-of-billing arrangements as raising the risk of upcoding; a flat fee per block of care gives the partner no stake in the size of the claim.[15]

5.4 Coinsurance and consent

Patients receive a statement for their 20% share as with any Part B service. A Medigap plan covers it for patients who carry one, and Qualified Medicare Beneficiaries owe nothing. Medicare does not allow the share to be waived routinely, and the program never asks the practice to. The HHS Office of Inspector General's exception covers a balance written off after a good-faith finding of the patient's financial need, or after reasonable collection efforts, provided the waiver is not advertised or routine. The regulation's text asks for reasonable collection efforts; it does not name a collections agency.[16]

Consent is where a statement stops being a surprise. Before the first billed month the patient hears that the program is available, that a monthly cost share may apply and that they can stop at any time, effective at the end of the month. Verbal consent is permitted and is documented in the chart. The consent script, the statement language and the patient materials are agreed with the practice's billing team before launch. Section 7 shows what the share is worth to the forecast at four collection rates.[17]

6. Value Analysis: The 24-Month Forecast

6.1 The headline economics

The forecast covers Principal Care Management across 2,000 active Medicare patients in scope, the practice's own working figure. Enrollment runs on the practice's own referrals: each of the 9 neurologists and APPs flags about 8 patients a month at the visit and 80% of them enroll. It is priced at the CY2026 Nevada amounts with half of patient coinsurance collected. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.[18]

	Year 1	Year 2	24 months
Net reimbursement	**$283,902**	**$524,893**	**$808,796**
CoachCare fees, including implementation, the Intergy setup and enrollment	$158,649	$274,788	$433,438
Net to the practice	**$125,253**	**$250,105**	**$375,358**
Practice margin	44.1%	47.6%	**46.4%**

[15] OIG Compliance Program Guidance for Third-Party Medical Billing Companies, 63 FR 70138 (December 18, 1998), note 40: "The OIG has a longstanding concern that percentage billing arrangements may increase the risk of upcoding and similar abusive billing practices."
[16] OIG Special Fraud Alert, 59 FR 65372 (December 19, 1994): the hardship exception "must not be used routinely". 42 CFR 1003.110: excludes a waiver that is not advertised or routine and follows a good-faith finding of financial need or reasonable collection efforts. CMS care-management guidance on Medigap and QMBs.
[17] CMS MLN909188, June 2025, consent elements; verbal consent permitted since CY2017 (81 FR 80250), documented in the medical record.
[18] CoachCare Value Analysis for Clinical Neurology Specialists, 2026; the full input list is in Section 9.2.

The margin moves from 44.1% in year one to 47.6% in year two because the one-time charges fall out and the program is full for all twelve months. Year two is the steady state: **$524,893 of net reimbursement, $250,105 of it kept**.

24 months	Net reimbursement	CoachCare fees	Net to the practice
PCM: principal care management ($30 first 30 minutes, $26 each additional, no platform fee)	$808,796	$422,000	**$386,796**
Implementation, Intergy setup and enrollment outreach		$11,438	−$11,438
Total	**$808,796**	**$433,438**	**$375,358**

Fees and net to the practice, 24 months, CoachCare Value Analysis. The care managers and the enrollment outreach team are embedded in the PCM fees, never a separate charge.

On this forecast's billing mix, each enrolled patient-month brings $85.77 of net reimbursement against $44.75 of CoachCare's PCM fees: most months carry the first 30-minute block, and about half carry additional time.

6.2 The ramp, month by month

Month	Patients enrolled	Net reimbursement	CoachCare fees	Net to the practice
M1	**18**	**$1,551**	**$5,990**	**−$4,439**
M2	48	$4,094	$2,436	$1,658
M3	89	$7,607	$4,386	$3,221
M4	138	$11,829	$6,677	$5,152
M6	251	$21,556	$11,839	$9,717
M8	361	$30,992	$16,762	$14,230
M10	468	$40,148	$21,540	$18,608
M11	510	$43,741	$23,312	$20,429
M12 onward	**510**	**$43,741**	**$22,899**	**$20,842**

Month 1 is negative because the one-time implementation fee and the Intergy setup post in that month against 18 patients. Every month after it is positive. Referrals ramp over the first five months as the flag becomes routine, then add about 59 patients a month until the pool fills in month 11. From month 12 the service line holds $43,741 a month of net reimbursement and $20,842 a month to the practice. Year one closes at $125,253 to the practice and year two adds $250,105.

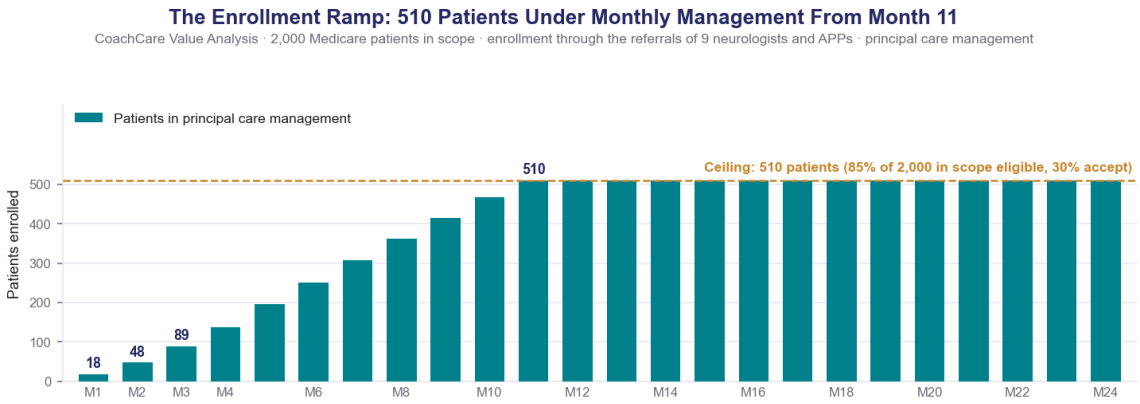


Figure 2 — patients enrolled in principal care management each month, on the clinicians' referrals. The program reaches its eligible pool in month 11 and holds it. CoachCare Value Analysis.

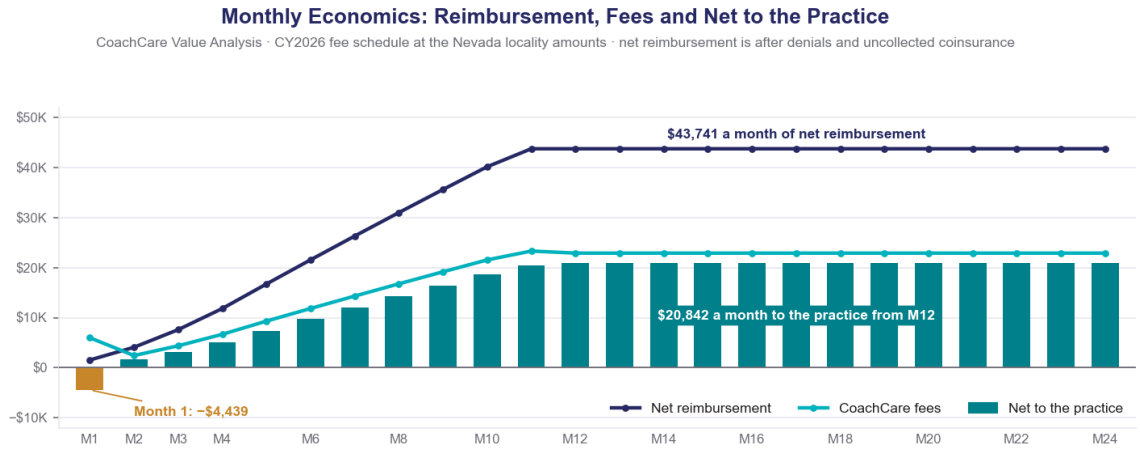


Figure 3 — monthly net reimbursement, CoachCare fees and net to the practice. CoachCare Value Analysis.

6.3 Referrals set the pace

The first lever is the flag at the visit. Referrals decide how fast the program reaches its pool, and so how many billed months the 24 months hold. The clinician's part is one flag in Intergy; CoachCare's enrollment outreach team does the calling and the consent.

Referral scenario	Pool full by	24-month net reimbursement	Net to the practice	Margin
6 referrals per clinician per month	M14	$741,216	$343,157	46.3%
8 per clinician per month, 9 clinicians: this forecast	**M11**	**$808,796**	**$375,358**	**46.4%**
10 referrals per clinician per month	M9	$849,727	$394,861	46.5%
The five neurologists as the only referrers	M19	$645,148	$297,382	46.1%
12 referring clinicians	M9	$859,462	$399,499	46.5%

CoachCare Value Analysis, a full workbook recalculation for each row with one input changed at a time; 2,000 Medicare patients in scope, 80% of referred patients enrolling.

Read the rows as a habit, not a headcount. At 10 referrals per clinician a month the pool fills five months sooner than at 6, and the practice nets $394,861 against $343,157. The four advanced practice providers carry close to half of the referral capacity: with the five neurologists referring alone, the pool takes until

month 19 and the practice nets $297,382. A monthly referral report by clinician is part of the program, so the habit is visible from the first month.

6.4 The panel sets the ceiling

Say the constraint out loud

At 2,000 patients in scope, referrals set the pace and the panel sets the ceiling. PCM eligibility is 85% of patients in scope, 1,700 patients, and 30% of them accept, so the ceiling is 510. By month 11 every patient the program can take is enrolled, and the census holds there for the rest of the 24 months. More referrals reach that number sooner; only a larger count of active Medicare patients raises it.

The Intergy count is discovery item number one. The 2,000 is a deliberately round working figure. A report of the Medicare patients seen in the last twelve months or scheduled in the next twelve replaces it, and every figure in this section moves with it.

Medicare patients in scope	Patients at the ceiling	Pool full by	24-month net reimbursement	Net to the practice	Margin
1,500	383	M9	$644,596	$298,375	46.3%
2,000: this forecast	**510**	**M11**	**$808,796**	**$375,358**	**46.4%**
3,000	765	M16	$1,060,303	$492,686	46.5%
4,000	1,020	M21	$1,207,266	$560,200	46.4%

CoachCare Value Analysis, a full workbook recalculation for each row; 9 referring clinicians at about 8 referrals a month.

The count raises the ceiling. Net to the practice rises from $375,358 at 2,000 patients to $492,686 at 3,000 and $560,200 at 4,000. With a larger count, referral pace decides most of the two years: a 3,000-patient pool takes until month 16 to fill and a 4,000-patient pool until month 21. On a larger panel, more referrals per clinician is what turns the extra patients into billed months sooner.

At the ceiling, 510 patients are under monthly management every month from month 11, each with a disease-specific care plan, a monthly call and a care manager who knows the case. Over 24 months the program produces **14,853 billed claim lines** for the practice's billers and **9,902 care-team hours** of outreach, care planning and documentation, about 4.8 full-time-equivalent years of staffing the practice would otherwise recruit, train and manage itself. The forecast also holds the in-scope count flat for two years; new patients enter the practice every month, and each one with a chronic neurological diagnosis becomes a referral after the first visit.

7. The Patient's Share

Medicare pays 80% of the allowed amount and the patient owes the other 20%, unless a supplemental plan picks it up. On a fixed-income Medicare panel some of that share never arrives. This forecast assumes the practice collects about half of it. Here is the same 24 months at four collection rates, with everything else held equal.[19]

Share of coinsurance collected	24-month net reimbursement	CoachCare fees	Net to the practice	Margin
All of it	$898,662	$433,438	$465,224	51.8%
Three in four	$853,729	$433,438	$420,291	49.2%
About half: this forecast	**$808,796**	**$433,438**	**$375,358**	**46.4%**

[19] CoachCare Value Analysis, full workbook recalculations at 100%, 75%, 50% and 0% of coinsurance collected, every other input unchanged.

Share of coinsurance collected	24-month net reimbursement	CoachCare fees	Net to the practice	Margin
None of it	**$718,929**	**$433,438**	**$285,491**	**39.7%**

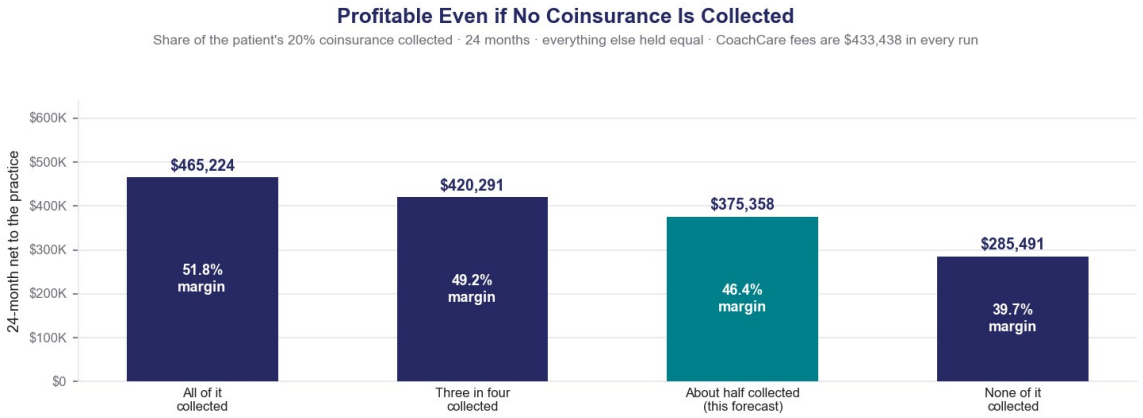


Figure 4 — 24-month net to the practice at four coinsurance collection rates. CoachCare Value Analysis.

Profitable even if no coinsurance is collected. The spread between collecting everything and collecting nothing is $179,732 over two years, and the program returns $285,491 at the bottom of that range. CoachCare's fees are the same in every row, because they are flat per block of care and never a share of collections. The program needs no change to the practice's collection policy to work. What it does need is a consent conversation that names the monthly share before the first statement, and statement language the billing team is comfortable with, both agreed before launch.

8. Policy Watch: The CY2027 Proposed Rule

The CY2027 proposed Physician Fee Schedule made headlines for its cuts to remote monitoring. The steepest cut falls on the remote-monitoring device-supply code 99454, −20.6% at the Nevada amount, and that code is not in this service line. Principal care management is not targeted; it moves only through the conversion factor and routine relative-value updates. The comment period closed on September 14, 2026, the final rule is due in early November 2026, and it takes effect January 1, 2027.[20]

	CY2026 final	CY2027 proposed	Change
99426, Nevada	$67.45	$66.70	−1.1%
99427, Nevada	$53.86	$54.27	+0.8%
The PCM service line, 24 months	**$808,796**	**$805,020**	**−0.47%, −$3,775**

Both PCM codes repriced at the proposed CY2027 Noridian Nevada locality 00 amounts, non-facility, on this forecast's own billing mix. Enrollment and acceptance held constant; this is the rate change alone.

[20] CMS-1848-P, CY2027 Medicare Physician Fee Schedule proposed rule; comment period closed September 14, 2026. CoachCare repricing at the proposed CY2027 Nevada locality 00 amounts (conversion factor $32.8409 against $33.4009): 99426 $67.45 to $66.70; 99427 $53.86 to $54.27; PCM line −0.47% (−$3,775), $808,796 to $805,020.

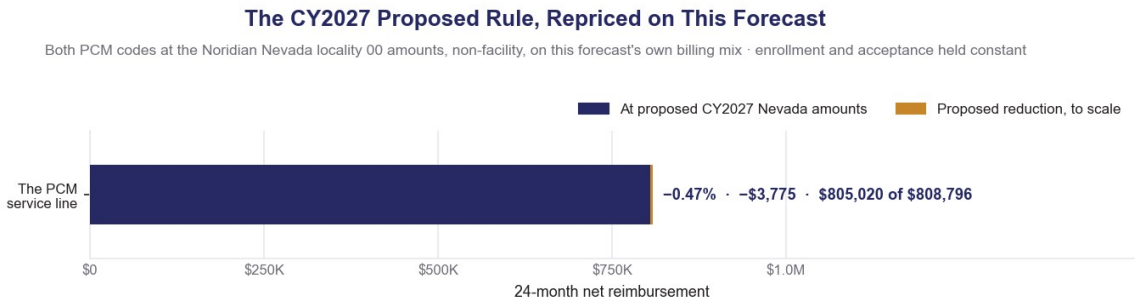


Figure 5 — 24-month PCM net reimbursement at CY2026 final and CY2027 proposed Nevada amounts; the sliver at the end of the bar is the proposed reduction, drawn to scale. CoachCare repricing of the Value Analysis.

Code	What it pays for	CY2026 national	CY2027 proposed national	Change
99426	Principal care management, first 30 minutes	$67.80	$67.00	−1.2%
99427	Principal care management, each additional 30 minutes	$54.11	$54.52	+0.8%

CY2026 Addendum B and CMS-1848-P proposed CY2027 Addendum B, national non-facility amounts, so the movement reads without a locality in the way. The repricing above uses Nevada amounts; the two bases do not reconcile to the dollar, by design.

The first-30-minute code moves down slightly and the add-on code moves up, so the line loses 0.47%, $3,775 over 24 months. A care-management service line built on staff time, not devices, sits outside the part of the fee schedule CMS is reworking. CoachCare will rerun this forecast against the final rates the week they publish.

9. Implementation

9.1 The first 90 days, and after

Window	What happens	Result at the end of it
Weeks 0–4 Integrate and charter	The Intergy referral flag configured and each clinician briefed on the referral criteria; the billing workflow agreed with the billing team; a named program lead; protocol sign-off for the epilepsy, Parkinson's, multiple sclerosis, dementia, headache and stroke-prevention PCM pathways; consent language, statement language and patient materials in the practice's branding; escalation routes set for each office	Integration live, referral flag live, pathways signed, the Intergy patient count in hand
Weeks 4–8 First referrals	Neurologists and APPs at both offices flagging eligible patients at the visit; CoachCare calling each referral within days; the first care plans and monthly calls; escalation routes tested with each office	18 patients enrolled in month 1
Months 2–11 Fill the eligible pool	Referrals become routine at both offices; a monthly referral report by clinician; first charges reviewed against the forecast; the monthly P&L review with the customer success advisor begins	48 patients by month 2, 89 by month 3, 510 by month 11; positive from month 2
Months 11–24 Widen the count	Replace the working figure with the Intergy count; extend the program to new patients as they are diagnosed; refine eligibility by condition against what the claims show	$20,842 a month to the practice; year two at $524,893 net reimbursement, $250,105 to the practice

9.2 The model inputs

Input	Value in this forecast
Medicare patients in scope	**2,000** active Medicare patients, the practice's own working figure, all of them in scope
Referrals	**9 referring clinicians, five neurologists and four advanced practice providers, each flagging about 8 patients a month; 80% of referred patients enroll; ramped 30%, 50%, 70%, 85% and 100% over months 1 to 5**
Eligibility and acceptance	PCM 85% eligible; 30% acceptance; 1.5% monthly attrition
Enrollment	CoachCare's enrollment outreach team calls each referral within days, with a small telephonic follow-up; no other enrollment channel in the forecast
Collections	2.5% denial rate; coinsurance 20% of allowed, 50% of it collected
CoachCare fees	$30 for the first 30 minutes (99426) and $26 for each additional 30 minutes (99427); no per-patient platform fee; implementation and Intergy setup one time; a small fee per new enrollment
EMR	Greenway Intergy: $2,500 one-time setup; no monthly or per-patient integration fee
Rates	CY2026 Physician Fee Schedule, non-facility, Noridian JF, Nevada locality 00, ZIP 89147; the same locality covers Henderson. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families.
Program	Principal Care Management (99426, 99427)

9.3 What we would confirm together

These are the discovery items. Each one lives in Intergy or is one conversation away, and the first window of the plan collects them.

1. **The Intergy count of active Medicare patients, by principal condition.** Unique Medicare patients seen in the last twelve months or scheduled in the next twelve, by office, and by neurological condition where the problem list allows: epilepsy, multiple sclerosis, Parkinson's disease and tremor, dementia, myasthenia gravis, chronic migraine on Botox or CGRP, neuropathy and post-stroke care. One-time electrodiagnostic referrals come out of the count. This replaces the 2,000, and every figure in Section 6 moves with it.
2. **The referral routine, eligibility and the launch pathways.** How the flag fits each clinician's visit and which clinicians start first, the share of patients with a qualifying principal condition, and which condition pathways in Section 3.1 go live first.
3. **Coinsurance collection history.** From the billing team: the current Medicare statement cadence, the number of attempts, the write-off policy, any written financial-hardship policy, and how Qualified Medicare Beneficiaries are handled today.
4. **The Medicare Advantage plan mix and each plan's terms.** Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. Which plans hold the practice's Medicare patients, and how each one pays 99426 and 99427, decides how far past Original Medicare the program reaches.
5. **Consent and patient-statement language.** The consent script with the cost-share disclosure, the wording on the monthly statement, and the white-labeled patient materials, agreed with the billing team before the first call.

10. Recommendations

1. **Make the referral flag a habit at every visit.** The clinician's part is one flag in Intergy; CoachCare calls each referral within days. All nine neurologists and APPs referring about 8 patients a month fill

the pool by month 11; at 10 a month it fills by month 9 and the practice nets $394,861. Review the monthly referral report by clinician from the first month.

2. **Launch Principal Care Management as one service line across both offices.** $375,358 to the practice over 24 months at a 46.4% margin on 2,000 patients in scope, positive from month 2, with nobody hired and nothing bought.
3. **Build every care plan around the condition the practice treats.** Disease-specific plans the neurologists own, on condition pathways the clinicians sign before launch: epilepsy, Parkinson's disease, multiple sclerosis, dementia, headache, stroke prevention, neuropathy and myasthenia gravis.
4. **Pull the Intergy count, by principal condition, in week one.** At 2,000 patients the count sets the ceiling. Between 1,500 and 4,000 patients, 24-month net to the practice runs from $298,375 to $560,200, and on a larger count referral pace decides most of the two years.
5. **Send Section 5 to the practice's healthcare attorney before contracting.** The supervision regulation, CMS's guidance on outside case management staff, the documentation trail and the flat-fee structure answer the questions an attorney asks of a care-management partner. A working call with the attorney is welcome.
6. **Bill coinsurance the way the practice bills any Part B service.** No routine waiver, a consent conversation that names the monthly share, and statement language agreed in advance. The program returns $285,491 even if none of the share is collected.
7. **Read the Medicare Advantage contracts early.** About 57% of Clark County's Medicare beneficiaries are in a plan. Medicare Advantage plans must reimburse at no less than the Medicare rate, a floor; individual contracts set their own terms for the care-management code families. The plan-by-plan read decides how far past Original Medicare the program reaches.
8. **Run the program inside Intergy from the first patient.** Enrollment by flag and signed note, the dictated notes and problem list flowing to the care team, charges by about the fifth business day, and the monthly summary in the chart beside every claim.
9. **Keep clinical governance where it is.** The clinicians sign the pathways and the care plans, receive escalations and make every clinical decision; the claims go out under Clinical Neurology Specialists; the revenue stays with the practice. CoachCare does the monthly work and documents it.

The Medicare panel Clinical Neurology Specialists already treats supports a $808,796 PCM service line at a 46.4% practice margin over 24 months, positive from its second month, on staff the practice does not have to hire. It starts with a flag at the visit.

About CoachCare

The experience to get it right

CoachCare runs care-management and remote care programs for more than 500,000 patients across over 400 managed conditions, with more than 10,000 clinicians on the platform. Its teams have stood up more than 1,000 implementations, its care-plan coding and billing stand behind more than 5 million claims, and the platform has enabled more than 4 million care actions.[21]

Why this partnership fits Clinical Neurology Specialists specifically.

[21] coachcare.com, company figures as published by CoachCare, 2026.

- **The integration Greenway itself offers.** Enrollment flags go out; charges, care summaries, enrollment status and tasks come back into Intergy. Clinicians keep dictating the way they do now, and nobody re-keys a note.
- **A staffed program, not a hiring plan.** Care managers at about 160 patients each, an outreach team that calls every referral within days, documentation and billing preparation are CoachCare's payroll. The clinician's part is the flag at the visit. The program lands at a 46.4% margin to the practice over 24 months.
- **Documentation where an auditor looks.** Consent, care plan, time logs and a monthly care summary in the practice's own chart for every patient, every month.
- **Paid per block of care, never per dollar collected.** $30 for the first 30 minutes of PCM care in a month and $26 for each additional 30, with no per-patient platform fee.
- **Care built around the diagnosis.** Task-based pathways for each condition: seizure logs and rescue plans, dose timing and fall screens, therapy adherence, caregiver calls. The practice's clinicians sign off on every pathway before launch.
- **A one-year agreement with real exits.** Ninety days' notice to end it, and the practice can unenroll any patient at any time. A dedicated customer success advisor reviews the service line's P&L every month, so the margin in this report is the margin the practice sees.

The ask is a working session with the practice's leadership and billing lead to replace the 2,000 working estimate with an Intergy count of active Medicare patients by principal condition, confirm the PCM pathways, and set a go-live date for the first enrollments.

Contact

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References & Data Sources

- **Clinical Neurology Specialists' own published materials** (cnsnevada.com, retrieved October 2026), for the practice profile, offices, clinicians and programs.
- **CMS provider and claims files** (data.cms.gov, retrieved October 2026): Medicare Physician & Other Practitioners by Provider and by Provider and Service, CY2024; Medicare Advantage State/County Penetration, October 2026 and July 2026.
- **Medicare payment rules:** the CY2026 Medicare Physician Fee Schedule final rule, Addendum B and RVU file, with the geographic indices for Noridian JF, Nevada locality 00, used for every dollar in this report; CMS-1848-P, the CY2027 proposed rule, for the proposed amounts and the comment deadline.
- **Supervision, concurrency and consent:** 42 CFR 410.26 (current eCFR text); the CY2017 Physician Fee Schedule final rule, 81 FR 80249 to 80255; the CY2020 final rule, 84 FR 62692 to 62697; the CY2022 final rule, 86 FR 65117 and 65275; CMS Chronic Care Management Frequently Asked Questions (updated August 16, 2022); CMS MLN909188 (June 2025).
- **Coinsurance and fees:** HHS Office of Inspector General Special Fraud Alert, Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 FR 65372; 42 CFR 1003.110; OIG Compliance Program Guidance for Third-Party Medical Billing Companies, 63 FR 70138.
- **Program operations:** the Greenway Intergy Integration overview (Greenway Health, 2024), and CoachCare's Care Management Programs standard operating procedures (March 2026) for the PCM workflow, the emergent protocol and care-management hours.
- **CoachCare Value Analysis for Clinical Neurology Specialists, 2026:** every financial and enrollment figure, the sensitivity runs and the CY2027 repricing.