



# Successful chronic care management

Six practices, in their own words

## Highlights

**How to enroll & engage patients**

**Best practices for complaint reporting & documentation**

**How to use workflows that work with your organization's work**

**Strategies to scale smartly & efficiently**

# A Message from **Our Founder**



Dear Reader,

## **Caring for chronic patients isn't easy.**

I know because I was diagnosed with T1 diabetes in 2001. It's taken more than daily shots and finger pricks to keep myself alive. My amazing doctor and his team spent countless hours without reimbursement coordinating care, answering questions, battling insurance companies, and filling out pre-certs. Even reassuring my family if the paramedics had to come.

In 2015, Medicare started reimbursing for that extra time. It might surprise you to know that today there are 30-plus recurring CPT Codes that cover it. The purpose of this resource guide is to show you how real providers and practices of all sizes are succeeding with them. My hope is they will give you confidence to explore them for your practice.

Thank you for caring for us. Before you dive in, here are some proof points around how our hundreds of customers have succeeded with Medicare's care management codes (CCM, RPM, PCM, BHI and others) so that you may explore confidently. They have:

- Generated \$220 million-plus in chronic care management and remote monitoring reimbursements
- Averaged more than \$10,000 per provider per month net-new reimbursement
- Activated more than 270,000 patients across 15-plus specialties
- Reduced hospitalizations by 29.4 percent

Your peers share several insights in the following pages. See what they have to share, then please allow us to introduce you to more in order to learn how your practice might do the same—or, better.

Gratefully,

## **Matt Ethington**

CEO and Chief Chronic Patient  
ChronicCareIQ

# Table of Contents

*Hint: Click the page numbers to navigate*

## Woodside Medical

[03](#)

### Key Takeaways:

- Technology brings proactive care to life
  - Supporting CCM patients does not mean adding more staff
  - Educate your patients on CCM
- 

## Home Physicians Group

[16](#)

### Key Takeaways:

- Find technology that works with your people and processes
  - Establish a team mindset
- 

## ARcare Federally Qualified Health Centers

[08](#)

### Key Takeaways:

- Meet patients where they are — technologically and geographically
  - The right platform can prevent staff burnout
- 

## Louisiana Cardiovascular & Thoracic Institute

[21](#)

### Key Takeaways:

- Connect the dots to enhance health literacy
  - Scale smartly
- 

## Better Weights to Better Health

[12](#)

### Key Takeaways:

- Clinical outcomes improve for all patients, not just those in the CCM and RPM programs
- Select a platform that supports a transition to value-based care

## Advanced Medical Care, PLLC

[26](#)

### Key Takeaways:

- Leverage existing relationships
- Make documentation — and reporting — easy



## Case Study

→ Woodside Medical

# Increasing reimbursement pays off in more ways than one

### The Breakdown

#### Location



#### The Details

- **2 Doctor**  
Family Practice
- **2 Nurse**  
Practitioners
- **Codes**  
CCM and RPM

#### By the numbers

**250+**  
managed CMC patients

**12%+**  
Increase in Medicare  
reimbursements  
using ChronicCareIQ

Few primary care groups in Arkansas have on-site X-ray or lab facilities or their own urgent care clinic, but Woodside Medical is one of them. The family practice serves all populations — from pediatric to geriatric — and prioritizes investment in technology that enhances patient outcomes and experiences. **Chief among those solutions is ChronicCareIQ, which supports Woodside in providing chronic care management and remote patient monitoring services for more than 250 patients.**

For registered nurse Miranda Dardenne, who previously worked in hospital case management before transitioning to Woodside, one of the platform's biggest benefits is preventing patients from ending up in such a hospital setting. Continued, proactive outreach about patients' vital signs and risk factors helps her team identify those trending in a direction who should be addressed in clinic instead of heading to the ER.

**“I transitioned over, and I love it,” said Dardenne. “They didn’t talk about this in nursing school, but chronic care management is a great opportunity to communicate with your patients in between visits, educate them on medications, educate them on other things to look for when you’re checking your blood pressure.”**

The benefits of using ChronicCareIQ are much more than clinical, however. Reduced hospitalizations along with enhanced patient engagement have yielded other changes like improvements in MIPS scores and patient-centered medical home reimbursements.

## Key Takeaway 1

### → Technology brings proactive care to life

Dr. Jim Carmical and his wife Dr. Katelyn Carmical have always prioritized innovative technology and approaches to practicing. As Woodside's co-owners, they offer telehealth appointments and support using smart devices to track key health metrics — no matter whether patients have chronic conditions or not — for a proactive versus reactive approach.



**Dr. Jim Carmical**

Woodside Medical founder and owner



“Other practices that don’t have chronic care management programs are missing out on an opportunity operationally, and in terms of patient outcomes. Patients tell me that it reminds them to take better care of themselves, and we see that in terms of reduced hospitalizations.”

Woodside Medical was the first practice in its region to offer a chronic care management program, however, and today is among only two area practices doing so. The first-mover advantage was key to their initial — and — ongoing success, Dr. Jim Carmical said. **“The positive word-of-mouth advertising among our elderly population has made the platform a worthwhile investment.”**

## Key Takeaway 2

→ Supporting CCM patients does not require more staff

For nurses like Dardenne, ChronicCareIQ is a solution that helps operationalize the work of managing the most critical patients that clinical teams would have to perform anyway. Now they are compensated for that time, and **by using ChronicCareIQ Woodside didn’t have to hire additional resources to form its care management program.**

Woodside also noted benefits from an integration with the athenahealth electronic health record system (EHR). Activities like reviewing lab results, care coordination, medication refills, referrals, and charting between visits are all linked to ChronicCareIQ, so time spent can be tracked.

A major component of that is also time spent on patient phone calls, which are also easily fed into ChronicCareIQ. Such integrations make reimbursement and reporting much more seamless, said Dardenne and Dr. Jim Carmical.

### Key Takeaway 3

→ Meet patients where they are — in person, or not

Dr. Jim Carmical said **patient-centric care requires a patient-centric platform.** So while his staff benefits from seamless workflows, those they help care for also benefit from an easy user experience, he said.

**“ChronicCareIQ’s patient-centered approach has significantly enhanced communication.** Our dedicated nurse staff has become a reassuring point of contact for patients, guiding them through chronic care treatments and ensuring a seamless experience,” Carmical said.

Dardenne said providing a superior patient experience starts from day one. Part of that is showing patients how to take — and share — vital signs. But another crucial component is training them about what chronic care management is, which she explains as managing conditions like heart disease and high blood pressure for today and tomorrow.



**“The program is really about preventing complications — and hospitalizations — in the long run,” she said. “That’s a message that resonates.”**

Dardenne advises other practices that having a direct line of communication with providers and nurses is a major selling point when it comes to patients' chronic care enrollment conversation, since patients have a partial fiscal responsibility to be in the program.



## Case Study

→ ARcare Federally Qualified Health Centers

# 'Seeing' is believing with superior monitoring capabilities

### The Breakdown

#### Location



#### The Details

- **90+** Practices
- **100+** Providers
- **Codes** CCM, RPM, BHI, and PCM

#### By the numbers

**3,500+**

patients in CCM or PCM

**1,500+**

patients dual-enrolled in CCM, RPM, and/or BHI

“We see all who need healthcare” has been ARcare’s motto since its founding in 1981. But it wasn’t until early 2023 once the organization onboarded with ChronicCareIQ that they had optimized clinical transparency and patient access.

Since then, ARcare’s 90-plus clinics across Arkansas, Kentucky, and Mississippi have grown from disparate solutions to a united platform, with just over 5,000 billable patients enrolled in RPM and CCM.

The practice doubled its number of CCM patients in one year thanks to a solution that patients and clinical staff find easy to engage with.

## Key Takeaway 1

### → Meet patients where they are— technologically and geographically

ARcare was founded in Augusta, Arkansas, and like many of the other communities where their clinics are located, the area “is so rural that we don’t have a Walmart, and we don’t have a McDonald’s,” said registered nurse Amanda Austin, Director of Remote Care Management.

She said that this geography means that in many cases, patients don’t have easy access to in-person primary care. **That makes chronic care management programs crucial for clinicians to consistently track and address the health conditions of some of the most vulnerable patients in the U.S.:** those in the South and Appalachia regions. Here, driving to a doctor’s office — if there is one — often takes more time than it does for patients in urban environments.

Besides access, another impediment is time.



**Amanda Austin**

Registered Nurse

Director of Remote Care Management at ARcare



“We knew we wanted to keep our program in-house, and ChronicCareIQ allows us to do that. When you outsource, you don’t have a nurse who knows the area, what resources are available, what food banks, what churches. CCM is a lot more than about being connected to a patient’s health only. It’s about feeling connected.”

“We have a lot of farmers, and people who work in factories. They’re not available during the day and pretty much available only after-hours,” said Austin. “These patients can message us through the [ChronicCareIQ] app at any time. Since we are in that rural area, cell service can be in and out. We have our farmers who are like, ‘Don’t call me, because I’ll be on a tractor and I won’t have service. But I will message you through the app’ (when I do have service).”

## Key Takeaway 2

→ Staff burnout is real, and technology often makes it worse — but the right platform changes that

**Patients aren’t the only ones who are happier thanks to ChronicCareIQ. ARcare’s clinical staff now has a lower volume of in-bound phone calls to manage because communications are balanced via the messaging portal.**

And because the platform flags patients who are trending in the wrong direction, the ARcare team is better able to prioritize who needs to be contacted or possibly seen in-person.

Austin said that **ChronicCareIQ’s protocol questions are not only written in such a way that they are easy for patients (many with limited health literacy) to understand, but so that nurses can also review responses that may indicate mental health struggles.** Addressing behavioral in addition to physical conditions leads to more comprehensive, whole-person care and greater job satisfaction for other nurses like herself, Austin said.

Austin said she and her team have never looked back on their choice of technology partner since adding CCM services after ARcare was successful with RPM. “We had a platform before that only offered RPM. Then when we decided to add CCM, we started looking around,” she said. “We have the same nurses doing CCM and RPM, and then of course we have our EHR — having different platforms for all three is just crazy. We just love CCIQ, and can’t imagine doing what we do any other way.”



## Chronic Conditions In the U.S

Data from the Centers for [Disease Control and Prevention’s Behavioral Risk Factor Surveillance System](#) show that 54.3% of U.S. adults reported at least one chronic condition in 2023. The CDC analysis noted regional differences, with the highest levels of chronic diseases concentrated in the South and Appalachia regions,

including:

- Hypertension
- Diabetes
- Cancer
- Arthritis
- Asthma
- Chronic obstructive pulmonary disease
- Depression
- Kidney disease

# Case Study

## → Better Weighs to Better Health

# Better Weighs to Better Health scales smartly, and proactively, with new technology and reimbursement opportunities

### The Breakdown

#### Location



#### The Details

- **1 Doctor**
- **3 Nurse Practitioners**
- **Codes**  
CCM, RPM, and APCM

#### By the numbers

From 2023 to 2024, Better Weighs to Better Health saw its MIPS scores increase

# 80%

As Alabama's most rapidly expanding city for several years running, Athens has some growing pains. Among those is a shortage of primary care physicians and specialists accepting new patients.

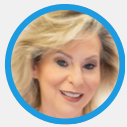
That means clinicians like Dr. Melissa Gray and licensed practical nurse Kristy Townsend have to be efficient with their team's time, and consider alternative approaches to maximize clinical and financial impacts for their growing practice of 5,000 patients (and counting). Besides offering primary and urgent care, Better Weighs has gotten innovative with preventative care, and offers wellness coaching, weight management, and hormone and IV therapies. **But perhaps their most successful strategy has been operationalizing the practice's CCM program to optimize Medicare reimbursements and help patients manage long-term conditions like diabetes and hypertension.**

## Key Takeaway 1

→ Clinical outcomes improve for all patients, not just those in the CCM and RPM programs

Before onboarding with ChronicCareIQ, Better Weighs was using color-coded Excel spreadsheets to manage patients registered for CCM programs, their conditions, and the amount of time spent on outreach and calls. Transitioning to a system that seamlessly integrates with their EHR, billing platform, and phone system has made all the difference when it comes to being more efficient, said Townsend, who is the CCM program director.

Today, she and the rest of **the team are able to walk in and immediately start their workday because of symptoms and metrics that were shared the night before or each morning**; the ChronicCareIQ platform automatically sorts and surfaces the neediest patients for care management teams.



**Kristy Townsend**

Licensed practical nurse and CCM Program Director



“Our program has an incredible impact on patients, their families, and our office staff. What we do takes multiple tasks off of the entire clinical floor team on a daily basis. This gives providers more time to perform sick visits, review labs and diagnostics, perform peer-to-peer reviews, or to chart.”

“Today’s landscape means providers are expected to see upward of 15 to 20 patients a day, so they just don’t have the time to do the things that care management teams can when supported by technology,” said Townsend.

“**Because of CCIQ, we can constantly communicate with the patient for health status changes and anticipate what those needs are going to be — often better than the provider can, given their other responsibilities across the practice.**”

“The implications are far-reaching and positive, Townsend said. “As part of getting patients signed up to use the CCIQ platform, we ask them about previous diagnoses. It’s surprising how many chronic conditions that we find that aren’t in charts — so the **CCM program is catching things that sometimes the patients forget to tell their provider.**” That yields not only more comprehensive care management, but more profitability, Townsend said.

Townsend said **the result of implementing a CCM program is better care for all patients across the practice**, because providers have more time to perform sick visits, review lab work, and chart since many of the more high-maintenance patients are assigned to a specific team.

## Key Takeaway 2

### → Select a platform that supports a transition to value-based care

Instead of the Centers for Medicare & Medicaid Services term “chronic care management,” Better Weighs to Better Health has branded its program for patients with what it considers a term that’s more approachable: “primary care management.” Townsend and her team have curated a comprehensive onboarding that includes not only questions about previous diagnoses, but contact details for patients’ specialists like cardiologists. The downstream effects of not having to track down such details later means each care management professional cumulatively saves time that can be reallocated to other patients.

New CCM patients are also asked numerous questions about social determinants of health like who they live with, if they feel safe, and challenges paying for prescriptions that affect adherence. Townsend said the framework assists her team in forming relationships with patients from the outset, while also helping them get durable medical equipment in their home, or install grab bars that can prevent falls that lead to fractured hips and other serious injuries.

Broadly, chronic care management programs like CCM, remote patient monitoring (RPM), and advanced primary care management (APCM) support practices in their transitions to value-based care. Townsend said this is certainly true at Better Weighs, and **since the practice’s first year after onboarding with ChronicCareIQ, they saw MIPS scores improve by 80 percent.**



The [Future of the U.S. Healthcare Industry: LaborMarket Projections by 2028](#) report projects a nationwide healthcare worker shortage of 100,000 by 2028.

# Case Study

## → Home Physicians Group

# For Home Physicians Group's platform choice, the third time's a charm

### The Breakdown

#### Location



#### The Details

- 12 Doctors
- 26 Nurse Practitioners
- Codes CCM and RPM

#### By the numbers

**9,000**  
patients

**2,800**  
patients enrolled in at least one CCM program

Home Physicians Group (HPG) struggled to scale with its first two chronic care management platforms. But **the organization hasn't looked back since onboarding with ChronicCareIQ**, said director of patient services and registered nurse Annie Miller.

“The other solutions weren’t what we needed for such a big practice,” she said. “The other platforms we had prior to ChronicCareIQ didn’t have the right workflows, or support as many codes, or the right phone system integrations.”

Miller said that ChronicCareIQ ticks all of those boxes — and more — and has helped the practice rapidly **triple its chronic care management patient load** in just two years.

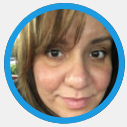
### Key Takeaway 1

→ Find technology that works with your people and processes

HPG is located in Florida, a state that outranks every other when it comes to the number of residents aged 65 or older. The majority of the practice’s patients are geriatric; 12 doctors and 26 nurse practitioners provide care across HPG clinics, in patients’ homes, and in skilled nursing, assisted living, and independent living facilities.

Having one platform that serves the needs of practitioners and their patients is vital, said Miller. **Other solutions HPG partnered with previously didn’t offer both CCM and RPM — and scaling the business by using separate platforms for each wasn’t feasible.** CCIQ’s turnkey phone system integration with RingCentral was also crucial when it came to onboarding and scaling the practice’s CCM and RPM programs, Miller said. There was no additional setup on HPG’s end, and little to no changes to existing workflows.

What has changed over the course of time is the breadth of features within CCIQ’s care plan functionality. CCM care plans are long-term...



## Annie Miller

Registered Nurse

Director of Patient Services at Home Physicians Group



“You can have a CCM program, but to have a great CCM program, you need the right support staff who know what patients need, and who provide the right follow-up. They need a platform that has a dashboard to help them make sure their patient load gets seen on a regular basis, and has alerts for those at risk — that’s what CCIQ is. And it’s amazing.”

...designed to manage chronic conditions across multiple providers and focus on coordinated, ongoing care outside of hospitals to prevent complications. Miller said that by working with ChronicCareIQ’s support and technical staff, HPG has been able to request and receive features that benefit their patients — and others across the country.

Care plans that connect the dots between care settings and providers align exactly with HPG’s mission of “whole-person care,” said Miller. The practice also offers wound care, podiatry and pharmacy services, visiting chaplains, and much more.



CCM care plans are long-term, designed to manage chronic conditions across multiple providers and **focus on coordinated, ongoing care outside of hospitals to prevent complications.**

## Key Takeaway 2

### → Establish a team mindset

Each of HPG's providers has about 150 CCM patients, which is well above standard thresholds for a successful program. Among the reasons the practice excels is because it has always prioritized hiring support staff with a robust onboarding and training process, said Miller.

HPG writes proprietary manuals for its chronic care management team. In addition, ongoing ChronicCareIQ University training sessions led by CCIQ's clinical staff are a cornerstone of the practice's program. HPG has improved its reimbursements and patient care with a hyper-focus on metrics that are easy to access with ChronicCareIQ, which is especially important toward the end of reimbursement cycles.

As a result, **the practice maximizes its profitability, while patients feel well cared for.** Continued communication instead of episodic outreach means that HPG's patient population benefits from an approach that can address social determinants of health (SDOH). The team recently connected a house-bound patient who had attended church frequently with clergy who perform in-home services. The HPG team also found a builder for another patient who was wheelchair-bound and needed a ramp installed at home.

**“Health isn't only about how you feel, but it's about a better lifestyle.** We love our patients and being able to perform those types of good deeds,” said Miller.



“If we didn’t have the CCM tools that we have — like CCIQ — we’d be spending more time on clerical tasks. We are making a direct impact on patients, which feels great.”



## HPG’s 3 keys to success with a CCM vendor

### 1.

Find workflows that work with your organization’s needs

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### 2.

Partner with a solution that offers multiple chronic care management codes

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### 3.

The best phone system integrations make operations and optimized reimbursements easier



## Case Study

→ Louisiana Cardiovascular & Thoracic Institute

Cardiology practice realizes superior patient care & financial outcomes by staying beats ahead with CCM

### The Breakdown

#### Location



#### The Details

- 1 Doctor
- 4 Nurse Practitioners
- Codes CCM and RPM

#### By the numbers

**314+**  
patients enrolled in RPM

Billing Percentage:  
**95%**

Heart disease is the leading cause of death in Louisiana, with a death rate 30 percent higher than the U.S. average. More than half of the population in Alexandria are people of color, who are more likely than any other ethnicity to be diagnosed.

But in this rural parish nestled in the center of the state, one practice is making a difference — one patient at a time.

The innovative diabetes management program at Louisiana Cardiovascular & Thoracic Institute (LACVT) has helped hundreds of patients with weight loss. Shedding pounds often means prescriptions need to be adjusted. But medication management at an in-person appointment every six months isn't an optimal approach, said Lori Francis, the clinical director of the practice's diabetes relief and cardiovascular program. That's why she and her team have made a conscientious effort to enroll those dropping a significant amount of pounds to add ChronicCareIQ to their routine.

"We've put these patients who've often been on high-blood pressure meds for decades into our RPM or CCM program. All of a sudden, they could be fatigued and hypotensive and they don't realize it — but we do," said Francis.

**"We can make adjustments to medications before they come into the clinic. And then when they are here, we have so much more data for the physician and nurse practitioner to make their visit even more impactful."**

That's just one success story of many since using ChronicCareIQ, said Francis.



**Lori Francis**  
Clinical Director



"We're able to capture the work we were doing before, but just didn't have the tools to capture. That's helped us as a clinic, in terms of providing more care for our patients, being more sustainable and profitable, and giving us the means — and justification — to increase our staff as well."

## Key Takeaway 1

### → Connect the dots to enhance health literacy

Making care less episodic has benefits besides clinical ones, said Francis. In an area where health literacy is often a challenge, LACVT has been able to educate patients via ongoing outreach. Tuesday Tips is a weekly newsletter with easy-to-understand wellness insights around rotating topics like nutrition and stress management.

The continued outreach encourages patients to stay connected with the practice — and for patients who read it on their smartphone, it means they're more likely to engage with nurses via ChronicCareIQ's messaging system. **"The CCIQ platform is really user-friendly for patients and for clinical staff. I think patients and their families are more comfortable reaching out through the messaging system** and prefer it over calling the office and potentially having to wait to speak with someone," Francis said.

**"We're in rural Louisiana, where health is not a huge priority for a lot of patients. They're probably not super excited about getting a blood pressure cuff and taking their blood pressure," said Francis. "But they are super excited about saving money."**

In terms of enrollment and having a conversation with patients about what chronic care management means for them, **LACVT has educational, printed literature; and a dedicated landing page on its website** for potential new CCM patients and their families to learn more about the program through a simple three-step process.



The average cost of a **Medicare hospital readmission is \$15,200 per patient.**

## Key Takeaway 2

### → Scale, smartly

LACVT was fortunate enough to have started its chronic care management program prior to the COVID-19 pandemic, when the practice's business manager learned about the clinical, financial, and operational benefits of CCM at a conference.

Cardiology is ground zero for chronic diseases in the United States, and the practice's business manager suggested that Francis operationalize an official program for work her team was already performing.

**“It was work we were already doing, but we weren't being compensated for it. So now we're able to do the work more efficiently, and scale by increasing our team with highly qualified staff,” Francis said.**



An estimated **129 million people in the U.S. have at least one chronic disease.** The most prevalent among these is **heart disease.**

When the world transitioned primarily to remote care in 2020, CCM was just what LACVT needed to take care of its most at-risk patients without bringing them into the clinic. Francis and her team were able to direct patients to the emergency room for abnormal vital signs, for instance, identifying transient ischemic attacks before strokes.

Having a program in place before lockdown meant they kept revenue coming in and patients healthy. **“Bottom line is, no money — no mission,” said Francis. “If you’re not profitable, then you can’t take care of patients and you can’t take care of your staff.”**

Having started five years ago, Francis realizes that LACVT’s business model may be more advanced than others just dipping their toes in the water. She has two pieces of advice for other practices just starting out.

The first is starting with existing staff and identifying downtime. “Most places have downtime somewhere, and these are staff that could help you manage these patients, many of whom they probably already know,” Francis said.

Her other advice? **Opt for ChronicCareIQ. “The integration with our EHR, athenahealth, works beautifully, and makes our billing easier so there’s less work for our in-house billers. Plus, patients just love it.”**



# Case Study

→ **Advanced Medical Care, PLLC**

# Better communication and seamless documentation make all the difference

## The Breakdown

### Location



### The Details

- **5 Doctors**
- **1 Nurse Practitioners**
- **15 Care Managers**
- **Codes**  
CCM, RPM, and PCM

### By the numbers

**1,700**  
CCM patients

Nurse practitioner Dina Lemkova-Seryy, has seen a lot of transformations in her 18 years at Advanced Medical Care. But among the most notable of those was the practice's decision **to transition its chronic care management program from outsourced to in-house five years ago.**

Today up to 25% of eligible patients are enrolled (mostly with cardiac conditions), and many of those re-engage year after year. Those numbers aren't the only reason Advanced Medical is technically successful, though. The majority of the practice's patients speak English as a second language, with broad swaths of those fluent in Russian, Ukrainian, Spanish, Korean, and Farsi seeking care. Providers (and many staff) speak at least two of those languages, creating a bond with patients so they don't need an interpreter to navigate their medical conditions or the healthcare system. **Operationalizing the practice's CCM program internally was a way to avoid common pitfalls that can come without a personalized touch within populations that have specialized needs like language** barriers, said Lemkova-Seryy.

**“We used to get these messages from outsourced people about our patients, and they knew nothing about them — they were really more ‘mechanical’ phone calls that were checking a box, and didn’t understand them or their questions,” she said. “So, I’d be stressed with these nonsensical messages, having to track down information by calling patients themselves. It was double the work, essentially.”**

**Today, the practice no longer has communication and bookkeeping barriers thanks to ChronicCareIQ**

## Key Takeaway 1

### → Leverage existing relationships

Patients aren't necessarily the only ones who should be screened for CCM program eligibility, said Lemkova-Seryy. Her advice for other practices building their program is to focus on building the right team and “listen for a smile,” because you can and never underestimate the power of a friendly voice.



**Dina Lemkova-Seryy**  
MS, nurse practitioner



“Chronic care management is absolutely here to stay. The benefits are vast. We have ways to prevent hypertensive crises, congestive heart failure emergencies. You can tell the patient to take their meds all you want, but you don’t know what they’re doing when they’re at home, and that’s a real challenge.”

“Having familiar voices on the phone is such a tremendous benefit,” especially when those professionals are speaking the same language, Lemkova-Seryy said. “In terms of initial enrollment, it makes all the difference because the patients will hear that voice and know it’s someone from the office of the doctor they trust, the process is just much faster and easier to know that’s the team you’ll be working with.”

There are two skill sets clinicians need to be successful in CCM, she added. The first is technical finesse, or a willingness to learn. The other proper — documentation — is less scientific, but just as important. “You can be an excellent clinician, but if you don’t have the right personality for this program, it’s going to be really hard to demonstrate to patients that you care about them over the phone. You have to be able to show them that you aren’t doing this to check off a box, but because you want to help them,” Lemkova-Seryy said.

**The Department of Health and Human Services Office of Inspector General (OIG)** recently announced its intention to audit Part B remote patient monitoring (RPM) services through 2025 to “determine whether providers furnished and billed for RPM services in accordance with Medicare requirements.”

**ChronicCareIQ’s fast and comprehensive reporting process ensures a smooth audit and documentation process.**

## Key Takeaway 2

→ Make documentation — and reporting — easy

Besides superior reporting capabilities, Advanced Medical chose ChronicCareIQ as its platform because it makes documentation easy.

“The first thing that you’re taught in nursing school is that if you didn’t document it, you didn’t do it,” said Lemkova-Seryy. “You need to make sure you’re with a vendor-partner that understands that and all the nuances of what chronic care management is. This isn’t just an EHR, and it’s not just a blood pressure monitoring company — it’s a platform that suits this exact program. ChronicCareIQ is just leaps and bounds above the rest when it comes to that.”

Lemkova-Seryy said the practice has been able to follow up on Medicare requests for documentation easily and quickly. Audits for providers in CCM and RPM programs aren’t infrequent, but having the tools to easily manage them is uncommon — unless those providers partner with ChronicCareIQ, she said.

“If we get a call from our billing department saying ‘Hey, Medicare is requesting a couple of charts,’ we can say, ‘OK, here you go’ — it only takes five minutes. The audit logs are there, the codes are appropriately listed with the appropriate dates with the appropriate times. Proper coding also means proper payment, which means we can pay the operational and professional costs that help us provide amazing patient care,” she said.

Since onboarding five years ago, ChronicCareIQ has excelled as a partner that understands — and is proactive about communicating — ongoing code changes that impact billing. ChronicCareIQ clinical and technical resources have supported Advanced Medical with upcoming compliance and regulatory shifts, Lemkova-Seryy said, and the solution provides a CCIQ University with training resources and webinars that the team references frequently.



# Schedule a Demo with us



Phone  
855-999-8089



Website  
[ChronicCareIQ.com](https://ChronicCareIQ.com)

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