ChronicCare partners with providers to offer valuebased care to their patients with chronic diseases. We can bridge the gap between office visits and provide patient support leading to **reduced hospitalizations**, **lower costs**, and **improved outcomes**.

- Proactively manage chronic conditions
- Diversity revenue streams
- Coordinate care securely



Principal Care Management (PCM)	Program	CPT	Payment
Our integrated approach allows us to deliver monthly care & emphasize prevention to patients suffering from one (1) chronic condition by enhancing the quality metrics of their healthcare.	30 additional min 30-min (clinician) 30 additional min	99424 99425 99426 99427 G0511	\$58.94 \$60.90 \$46.50

Chronic Care Management (CCM)	Program	CPT	Payment
CCM is the monthly care coordination that occurs outside of the regular office visit for patients with multiple chronic diseases. Two-thirds of Medicare patients are eligible, which means many of your patients can benefit from chronic care management services.	20 additional min 60-min per month	99490 99439 99487 99489 99491 99437 G0511	\$47.15 \$131.96

Remote Patient Monitoring (RPM)	Program	CPT	Payment
RPM empowers healthcare providers to remotely monitor vital signs and health trends. This enables medical professionals to deliver personalized care and intervene early. We provide free monitoring devices such as glucometers to your patients.	20 additional min Initial device setup	99457 99458 99453 99454 G0511	\$38.64 \$19.65

Transitional Care Management (TCM)	Program	CPT	Payment
TCM focuses on the post-discharge period (30 days) when patients transition from a hospital or	- (Within 14 days)	99495	\$203.34
other healthcare facility to their home or another setting. It aims to prevent readmissions by providing face-to-face visits within 7 or 14 days of	High complexity (Within 7 days)	99496	\$275.05
a patient's discharge.			

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