PRISTINE
Healthcare Solutions

Remote Patient Monitoring (RPM)
Chronic Care Management (CCM)

Redefining Remote Patient Monitoring with Simplicity

We Offer:

Always Best Care is redefining remote patient monitoring with easy patient set-up and use allowing seniors to actively engage in their care from the comfort of their home. Their Remote Care Solution allows caregivers to engage patients with a unique 2-way cellular console and voice-centric communication.

Easy For Doctors

- No upfront capital
- Zero maintenance
- No disruption to office workflows
- 2-ways cellular console for direct communication
- Conversational AI for added work efficiencies & improved work-flows
- Real-time patient information
- Increase revenue stream through remote monitoring CPT codes
- Increase work capacity to provide care tp more patients and grow scope of your practice

Easy For Patients

- Simple to set-up & use
- No installation
- No internet needed
- Voice centric communication to receive advice and encouragement to take daily vital sign measurements
- Conditional reminders
- High patient compliance
- Increased access to care
- Minimize risk of exposure to viruses by reducing visits to doctor's offices and hospitals

Improved Patient Outcomes
When patients and providers are better connected, everyone wins.

Made simple for the Doctor and Patient

(469) 444-7269 | pcc@mypristinehcs.com

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- 75% Reduction in ER visits
- 75% Reduction in 30-day readmission hospital rates
- 50% reduction in hospital admissions

According to source & Statistic research market MSI International, BCBS, Harvard Health & Business Insiders.

Complete Solution

By collecting data and securely transmitting that information daily, providers can proactively monitor patients and intervene on a timely basis while reducing operational costs.

The time to get started with remote patient monitoring is now. Provide timely and expanded care: reduce readmissions and emergent care visits. Improve patient outcomes and generate additional reimbursement with an end-to-end Remote Care Solution.

DOES YOUR OFFICES HAVE THE TIME AND RESOURCES TO MONITOR MULTIPLE DASHBOARDS FOR MULTIPLE PATIENTS?

The Time is Now

For Reimbursement: CMS regulations now allow for reimbursement

For New Revenue: That follows new CPT codes for RPM

For Patient Satisfaction: Leads to higher quality leads

For Improved Compliance: Improved outcomes

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We strive to reach the individual's goals as well as the practitioner's goals of effectiveness in treatment and efficacy of care.

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Chronic Care Management (CCM)

What is Chronic Care Management?

Chronic Care Management (CCM) is a Medicare program designed to help patients maintain their chronic health conditions. It aims to offer patients continuous support and access to healthcare between appointments, even when they are at home. To qualify for CCM, a patient must be a Medicare beneficiary and have at least two chronic health issues expected to last a minimum of one year or for the rest of the patient's life.

What does CCM include?

CCM services involve organized documentation of patient health details and the development of thorough electronic care plans.

It also includes overseeing transitions in care and other aspects of managing care. In addition, CCM encompasses managing medications, coordinating patient care, and promptly sharing health information both within and outside the practice.

Our mission is to support individual health ambitions while facilitating practitioners in providing targeted and successful care.

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How does CCM benefit healthcare providers?

Patients with multiple chronic conditions can present complex challenges in terms of management and coordination of care. They may consult with various specialists or be on several medications, necessitating collaboration among healthcare professionals. Ensuring proper coordination means that providers can access critical health information and test results promptly when needed.Integrating CCM into patient care allows providers to maintain consistency and offer the best comprehensive care. Additionally, CCM can reduce staff workload and minimize non-billable time. By encouraging patients to take an active role in their healthcare, providers can streamline processes and make patient management more efficient.

How does CCM benefit patients?

CCM prioritizes a continuous and personalized relationship between patients and their chosen care team members. This helps patients with chronic illnesses work toward their health goals while benefiting from 24/7 access to care and health information. Patients receive preventive care and are more engaged in their health journey, as are their caregivers. CCM also facilitates the prompt sharing and utilization of patient health information.

Patients with multiple chronic conditions often face complex care needs that can be difficult to manage independently. Working with a care manager can provide crucial support in addressing their individual medical requirements. CCM enhances care coordination, offering services outside of typical clinic visits and enabling patients to navigate their care more effectively.

CPT Codes for CCM

CPT code 99490
Non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.

CPT code 99439
Each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified healthcare professional (billed in conjunction with CPT code99490).

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Remote Patient Monitoring (RPM)

What is Remote Patient Monitoring (RPM)?

Remote Patient Monitoring (RPM) is a program designed for patients with acute or chronic health conditions, providing them with a mobile device to assist in the ongoing management of their condition. The program allows healthcare providers to collect specific health data from patients, enabling them to adjust medications and create tailored care plans accordingly.

To qualify for RPM, a patient must be diagnosed with at least one chronic health condition. This encompasses a range of conditions such as hypertension, hypotension, diabetes, chronic obstructive pulmonary disease (COPD), chronic heart failure, and others.

Devices that are commonly used in RPM include:

Blood Pressure
Weight Scale
Thermometer
Monitor Pulse Oximeter
Blood Glucose Monitor

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How does RPM benefit healthcare providers?

Managing patients with chronic conditions can be challenging when patients only visit the doctor's office every few months. With RPM technology, providers can offer more personalized care and monitor patient trends more effectively due to the increase in available patient data. This technology also allows practices to boost their revenue while reducing staff inefficiencies.

How does RPM benefit patients?

Using RPM for managing acute or chronic conditions can greatly enhance the patient's quality of life. It allows individuals with chronic illnesses to spend more time at home with their families instead of frequenting hospitals and doctor's offices. RPM's primary aim is to prevent problems from escalating into crises by enabling medical professionals to monitor readings and detect changes in health trends early on.

RPM helps providers fine-tune medication plans for better management of patient conditions, thereby potentially reducing trips to the emergency room. The main advantage of RPM is that it empowers patients to use mobile medical devices to measure vital signs such as blood pressure, weight, oxygen levels, heart rate, and glucose levels. They can then send these measurements to their doctors in real-time without needing to visit a medical facility. This approach offers substantial benefits for long-term management of chronic conditions and encourages more frequent communication between patients and healthcare providers.

CPT Codes for RPM

CPT code 99453
Initial set-up and patient education of monitoring equipment (billed in conjunction with CPT code 99454). Each patient must initially be educated about the program, including how to use the device, on a one-time basis

CPT code 99454
Device(s) supplied with daily recording(s) or programmed alert(s) transmission, each 30 days.(Initial collection, transmission, and report/summary services to the clinician managing the patient). Minimum of 16 days of readings transmitted in a 30-day period to be billable.

CPT code 99457
Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/ physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

CPT code 99458
Each additional 20 minutes of clinical staff time spent providing RPM services and review directed by a physician or other qualified healthcare professional (billed in conjunction with CPT code 99457)