For the Health of Your Practice

Preventive Medicine
About our speaker and partnership

Danielle Taimuty, MA, CPC, CEMC - Director of Client Success

- Danielle has been in the industry for 25+ years. Her background includes billing manager for an independent cardiology group, insurance claim adjudicator, insurance auditor and owner and founder of Medical Billing Solutions Services, Inc., now part of Formativ Health
- Certified Professional Coder
- Certified Evaluation and Management Coder

The Care Centered Collaborative at The Pennsylvania Medical Society has selected Formativ Health as its partner to assist practices in need of revenue cycle and other management services.

The information enclosed was current at the time it was presented. Policies change frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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This presentation is a general summary that explains certain aspects of Medicare and various commercial carriers, but is not a legal document. The official program provisions are contained in the relevant laws, regulations, and rulings.

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Learning Points

- How and When to Billing Preventive Services
- Medicare’s new 2018 Preventative Prolonged Services
- Alcohol Misuse Screening and Counseling
- Depression Screening
- Obesity Screening and Counseling
- Tobacco Use Cessation
How and When to Bill Preventative Services

Preventive medicine is practiced, in some form, by the majority of medical providers to keep their patients healthy. Preventive medicine focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death.

• In most cases, preventative services can be billed at the same time as an illness
• Many Preventative services have frequency guidelines, it is important to check eligibility on your patients to determine if the patient has met their benefit allowance
• Most carriers follow the U.S. Preventive Services Task Force (USPSTF) guidelines https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

“The purpose of risk assessment is not to categorize individuals according to a test result nor even as to their overall risk, but rather to identify those who can be helped, or helped most, by preventive action.”

---Geoffrey Rose, MD, PhD
Medicare’s Interactive Preventative Coverage Tool

### MEDICARE PREVENTIVE SERVICES

<table>
<thead>
<tr>
<th>SELECT A SERVICE</th>
<th>FREQUENTLY ASKED QUESTIONS</th>
<th>RESOURCES</th>
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<td>Alcohol Misuse Screening and Counseling</td>
<td>Annual Wellness Visit (AWV)</td>
<td>Bone Mass Measurements</td>
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<td>Diabetes Screening</td>
<td>Diabetes Self-Management Training (DSMT)</td>
<td>Glaucoma Screening</td>
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<td>Influenza Virus Vaccine and Administration</td>
<td>Initial Preventive Physical Examination (PPE)</td>
<td>Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)</td>
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<tr>
<td>Prostate Cancer Screening</td>
<td>Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests</td>
<td>Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIVBC) in Females (STI HTBC)</td>
</tr>
</tbody>
</table>

[https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)
Prolonged Preventive Services – New in 2018

- G0513 Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (listed separately in addition to code for preventive service)

- G0514 Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (listed separately in addition to code for preventive service)

- Provider face to face time

- Much of the work of a wellness visit, data collection, recording the patient’s history, screening for depression and activities of daily living, is done by staff members. Their time is not counted for either the wellness visit code or the additional prolonged services codes.
<table>
<thead>
<tr>
<th>Code</th>
<th>Brief description</th>
<th>Intraservice time of physician, NP, PA</th>
<th>Threshold to bill G0513</th>
<th>Threshold to bill G0513 &amp; G0514</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0402</td>
<td>Welcome to Medicare visit</td>
<td>30</td>
<td>46</td>
<td>76</td>
</tr>
<tr>
<td>G0438</td>
<td>Initial annual wellness visit</td>
<td>30</td>
<td>46</td>
<td>76</td>
</tr>
<tr>
<td>G0439</td>
<td>Subsequent annual wellness visit</td>
<td>25</td>
<td>41</td>
<td>71</td>
</tr>
<tr>
<td>Q0091</td>
<td>Obtaining a screening pap smear</td>
<td>16</td>
<td>32</td>
<td>62</td>
</tr>
<tr>
<td>G0101</td>
<td>Pelvic and clinical breast exam, screening</td>
<td>10</td>
<td>26</td>
<td>56</td>
</tr>
<tr>
<td>G0104</td>
<td>Flexible sigmoidscope, cancer screening</td>
<td>17</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>G0105</td>
<td>Screening colonoscopy, high risk individual</td>
<td>30</td>
<td>46</td>
<td>76</td>
</tr>
<tr>
<td>G0121</td>
<td>Screening colonoscopy, low risk individual</td>
<td>30</td>
<td>36</td>
<td>76</td>
</tr>
<tr>
<td>G0296</td>
<td>Visit to determine lung cancer screening eligibility</td>
<td>15</td>
<td>31</td>
<td>61</td>
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</tbody>
</table>
### Prolonged Preventive Services – New in 2018

<table>
<thead>
<tr>
<th>Code</th>
<th>Brief description</th>
<th>Typical time with staff</th>
<th>Threshold to bill G0513</th>
<th>Threshold to bill G0513 &amp; G0514</th>
</tr>
</thead>
<tbody>
<tr>
<td>76706</td>
<td>Ultrasound, abdominal aorta, real time screening for AAA</td>
<td>32</td>
<td>48</td>
<td>78</td>
</tr>
<tr>
<td>76977</td>
<td>Ultrasound bone density measurement and interpretation, peripheral site(s), any method</td>
<td>7</td>
<td>23</td>
<td>53</td>
</tr>
<tr>
<td>77067</td>
<td>Screening mammography, bilateral</td>
<td>22</td>
<td>38</td>
<td>68</td>
</tr>
<tr>
<td>77063</td>
<td>Screening digital breast tomosynthesis, bilateral</td>
<td>12</td>
<td>28</td>
<td>58</td>
</tr>
<tr>
<td>77078</td>
<td>CT, bone mineral density study, 1 or more sites, axial skeleton</td>
<td>29</td>
<td>45</td>
<td>75</td>
</tr>
<tr>
<td>77080</td>
<td>Dual-energy X-ray absorptiometry, bone density study, 1 or more sites axial skeleton (eg, hips, pelvis, spine)</td>
<td>33</td>
<td>49</td>
<td>79</td>
</tr>
<tr>
<td>77081</td>
<td>Dual-energy X-ray absorptiometry, bone density study, 1 or more sites appendicular skeleton (peripheral) (eg, radius, wrist, heel)</td>
<td>22</td>
<td>38</td>
<td>68</td>
</tr>
</tbody>
</table>
Medicare – Alcohol Misuse Screening / Counseling

- G0442 - Annual alcohol misuse screening, 15 minutes
- G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- Frequency
  - Annually for G0442
  - For those who screen positive, 4 times per year for G0443
- Can be billed with other preventive services

- *Follows Five A’s approach adopted by USPSTF
Medicare - Alcohol and/or Substance Abuse Screening and Counseling

- G0396 - Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST), and brief intervention 15 to 30 minutes
- G0397 - Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST), and brief intervention greater than 30 minutes
- G0396 & G0397 - CMS states that the service consists of the following components, abbreviated "SBIRT": Structured assessment, Brief intervention, Referral to treatment

*Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization
*Drug Abuse Screening Test (DAST) asks for yes/no responses to 28 questions about drug use, and a score over 12 indicates a substance abuse problem.

https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf
COMMERCIAL - Alcohol and/or Substance Abuse Screening and Counseling

- 99408 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- 99409 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST)*, and brief intervention (SBI) services; greater than 30 minutes

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.
COMMERCIAL - Alcohol and/or Substance Abuse Screening and Counseling

- 99408 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- 99409 - Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST)*, and brief intervention (SBI) services; greater than 30 minutes

If the patient tests negative for the screening and does not require “intervention”, bill for just the testing.

- 96160 Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
Administration of Patient-focused Health Risk Assessment

- 96160 Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
  - May be billed for each instrument used
  - Example instruments –
    - Acute Concussion Evaluation (ACE)
    - CRAFFT Screening Interview (Adolescent Sub Abuse)
    - SOAPP-R (opioid risk)
    - Fall Risk Assessment Tool (FRAT)
- Does not include interpretation or diagnosis
- Includes Scoring and documentation
- Typically completed by a non-physician clinical staff member (under direct supervision)
Preventive counseling and/or Risk Factor Reduction

**Codes** (99401 – 99404) are used to report services provided to individuals *at a separate encounter* for the purpose of promoting health and preventing illness.

<table>
<thead>
<tr>
<th>Description of service</th>
<th>ICD-10</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary counseling and surveillance</td>
<td>Z71.3</td>
<td>99401 (15 min)</td>
</tr>
<tr>
<td>Exercise counseling</td>
<td>Z71.82</td>
<td>99402 (30 min)</td>
</tr>
<tr>
<td>Other specified counseling</td>
<td>Z71.89</td>
<td>99403 (45 min)</td>
</tr>
<tr>
<td>Counseling concerning problems related to lifestyle</td>
<td>Z00-Z72.9</td>
<td>99404 (60 min)</td>
</tr>
</tbody>
</table>
Medicare Intensive obesity Counseling

Intensive behavioral therapy for obesity: Face-to-face behavioral counseling by a primary care provider in a primary care setting for patients with obesity, 15 minutes:

- G0447 – face-to-face behavioral counseling for obesity, 15 minutes

- G0473 – face-to-face behavioral counseling for obesity, group (2–10), 30 minutes.

- Can be billed in addition to E&M services
Medicare Depression Screening

G0444 - Annual depression screening, 15 minutes

Annual Screening

Medicare covers annual screening for adults for depression in a primary care setting, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, Physician Assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.

PHQ-9 Depression screen questionnaire:
http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
Commercial Depression Screening

• 96127 - Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

• May be reported with multiple units to represent each form (standardized instrument) administered during a visit.

• When a standardized screening or assessment is administered along with any E/M service (eg, preventive medicine service), both services should be reported, and modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) may need to be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

PHQ-9 Depression screen questionnaire:
http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
Medicare and Commercial Smoking / Tobacco Counseling

• 99406 - Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

• 99407 - Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

• Two cessation attempts are covered per 12-month period. Each attempt may include a maximum of four intermediate or intensive counseling sessions. Therefore, the total annual benefit covers up to eight smoking cessation counseling sessions in a 12-month period.

• DOCUMENTATION REQUIREMENTS

  • The patient’s tobacco use
  • Advised to quit and impact of smoking
  • Assessed willingness to attempt to quit
  • Providing methods and skills for cessation
  • Medication management of smoking session drugs
  • Resources provided
  • Setting quit date
  • Follow-up arranged
  • Amount of time spent counseling patient

*http://www.freedomfromsmoking.org
Medicare Intensive Behavioral Therapy for Cardiovascular Disease

Intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit) consists of the following three components:

• **G0446** - Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes (Intensive behave therapy cardio dx)

• Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;

• Screening for high blood pressure in adults age 18 years and older; and

• Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age and other known risk factors for cardiovascular and diet-related chronic disease.

• Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.

• One face-to-face CVD risk reduction visit annually

• *Follows Five A’s approach adopted by USPSTF*
Medicare Diabetes Outpatient Self-Management

- G0108 -Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 -Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
- To qualify for reimbursement, these DSMT services must be part of a plan of care prepared by a physician or qualified non-physician practitioner (QNPP). In addition, they must be furnished by a diabetes self-management program that has been accredited by the American Diabetes Association or the American Association of Diabetes Educators, the two CMS-approved national accreditation organizations
- Include referring physician on claim
- Diabetes is diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria:
  - a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions;
  - a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or
  - a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.
Medicare Diabetes Outpatient Self-Management

- Initial year: Up to 10 hours of initial training within a continuous 12-month period
- Subsequent years: Up to 2 hours of follow-up training each calendar year after the initial 10 hours of training has been completed
- Copayment/coinsurance applies
- Deductible applies

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program.html
Commercial (Diabetes) Training and Self-Management

- 98960 - Individual, initial or f/up face-to-face education, training & self-management, by qualified non-physician HCP using standardized curriculum (may include family/caregiver), each 30 min.
- 98961 - Group of 2 - 4 pts, initial or f/up, each 30 min.
- 98962 - Group of 5 - 8 pts, initial or f/up, each 30 min.
- In most cases, neither AADE accreditation nor American Diabetes Association recognition of DSMT program required
- For pts with established illnesses/diseases or to delay co-morbidities
- Physician/NPP must Rx education and training
- Non-physician’s qualifications and program’s contents must be consistent with the scope of license and state regulations
- Coverage varies
Medicare and Commercial Medical Nutrition Therapy

- 97802 - Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97803 - Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes
- 97804 - Medical nutrition therapy; group (2 or more individuals), each 30 minutes
- Medicare requires services by rendered by a registered/licensed dietician or Nutrition Professional. Most carriers will also follow this rule.
- Most commercial carriers have published policies specific to MNT as well as limitations
- Append modifier 33 when providing the service is listed on the preventive service list Affordable Care Act.
- First year: 3 hours of one-on-one counseling
- Subsequent years: 2 hours
- Copayment/coinsurance waived
- Deductible waived

https://www.kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/
Medicare and Reassessment - Medical Nutrition Therapy

When there is a change in Diagnosis that needs:

- **G0270** - Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

- **G0271** - Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
Medicare Intensive Behavioral Counseling for Sexually Transmitted Infections

- G0445 - Semi-annual high intensity behavioral counseling to prevent STIs, individual, face to face includes education skills training & guidance on how to change sexual behavior, 30 minutes
- Up to 2 times per calendar year
- This code may be paid on the same date of service as an annual wellness visit (AWV), evaluation and management (E&M) code
- 1 unit per day
- If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs
- Deductible and coinsurance do not apply
**Clinical Documentation Requirements for Counseling**

Assessed: Asked about/assessed behavioral health risk(s) and factors affecting choice of behavior change goals/methods.

Advised: Given clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.

Agreed: Collaboratively selected appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.

Assisted: Using behavior change techniques (self-help and/or counseling), aided the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.

Arranged: Scheduled follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
About Formativ Health

We are redefining the ambulatory patient and provider experience throughout the health care ecosystem.

Our purpose
To transform the patient and provider experience and make health care better for both.

Our approach
We partner with physician practices, hospitals, and health systems to improve financial health, enhance the patient experience, and free up physicians to focus on what they do best – taking care of patients.
What Makes Us Different?

By Physicians, For Physicians
We are purpose-built by physicians with two decades of experience leading one of the largest health systems in the United States.

Comprehensive Patient Services
We offer the most comprehensive, high-touch patient services in the ambulatory market, easing the patient’s clinical and financial journey, building patient loyalty and enabling physicians to focus on patient care.

End-to-End Technology Enabled Services
Our services are the first to span the care continuum, from patient access through collections and beyond. We offer a portfolio of solutions that can be implemented in either modules or as an end-to-end solution, based on the provider’s needs.

Agnostic Technology
Our services are able to work with the provider’s existing technology and do not require system replacements that create operational disruptions.
How Can Patient Access Services Help You With Prevention and Quality

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<th>Inbound Phone Calls</th>
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<tbody>
<tr>
<td>Appointment Scheduling – Support primary, specialty care practices, insurance products, and community referrals</td>
</tr>
<tr>
<td>Registration – Occurs at the time an appointment is scheduled</td>
</tr>
<tr>
<td>Insurance Verification - Verify patient’s coverage is active and also provides basic benefits. Verify specific benefits with the carrier per CPT code</td>
</tr>
<tr>
<td>Authorizations – Contacting insurance companies, providing clinical data and obtaining a pre-authorization for services</td>
</tr>
<tr>
<td>Non-Appointment Assistance, such as patient requests (e.g., medication refills, results, records, directions) in coordination with the office</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Patient Outreach</th>
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</thead>
<tbody>
<tr>
<td>Financial Counseling – Leverages dedicated support team to help identify financial payment arrangement solutions for uninsured patients and or patients receiving non covered services</td>
</tr>
<tr>
<td>Referrals – Outbound calls to existing patients of the medical group, where a provider has written a referral order for a specialist, and for affiliated physicians utilizing HER</td>
</tr>
<tr>
<td>Post Discharge – Post-ED, Discharge, and Urgent Care Appointments, Direct appointment scheduling from these settings</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Care Coordination</th>
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</thead>
<tbody>
<tr>
<td>Population Health – Eliminate disparities in preventative care access by placing outbound calls to patients with gaps</td>
</tr>
<tr>
<td>Chronic care management – schedule follow up to improve clinical outcomes and reduce healthcare costs</td>
</tr>
</tbody>
</table>
Our Capabilities

High-Touch Patient Access
Enhancing the patient, staff, and physician experience while improving financial outcomes

High Touch Patient Access Center
- Handle all inbound and outbound calls
- Optimize administrative workflow and scheduling

Call Management
- Answer all patient calls, direct "clinical calls" to a centralized nursing group
- Scheduling, insurance verification, registration, referral management, requests

Care Coordination
- Schedule post discharge care, disease and chronic care management, overdue routine appointments
- Identify gaps in care

Revenue Improvement
- Manage appointment wait list, no shows, cancellations
- Counsel patients on payment options, financial support services

Quality Assurance
- Record 100% calls; screen capture 20%
- Review agents twice yearly; ongoing peer review and management reviews
- Generate scorecard to analyze each agent call

Staff Competency
- Low attrition with existing staff
- Targeting bachelor's degree candidates
- 8-week training program

Workforce Optimization
- Predictive modeling for staffing based on day of week, weather patterns, geography, type of practice, utilization rates, gaps in services/specialists needed, operational gaps

Practice Operations
Managing administrative functions so that physicians can focus on patient care

Personnel
- Accounting, human resources, benefits management, research & benchmarking, practice governance

IT and Infrastructure
- Server maintenance, network management, EHR & PM systems, helpdesk, data conversion, document management, scanning
- Hosted cloud services, system level monitoring

Group Purchasing
- Group purchasing management, contracting for supplies and pharmaceuticals

End-to-End Revenue Cycle Technology and Services
Redefining revenue cycle management with tailored solutions that span the care continuum

Outsourcing
- Full and partial revenue cycle services outsourcing
- Agnostic Technology
- Portfolio of agnostic technology across front, middle, back of revenue cycle

Analytics
- Analytics that leverage data to reveal strategic insights and empower data-driven decision making

Advisory Services
- Advisory services that improve processes, increase efficiencies and streamline operations

Education Services
- Education services that improve staff performance and retention
Questions

Contact Danielle Taimuty with any additional questions
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Thank you for joining Formativ Health

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