PROVIDER INSIDER plus

United Healthcare | Rocky Mountain Health Plans

April 2023

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Rocky Mountain Health Plans Transition Updates

IMPORTANT NOTICE: Authorization submission process for dates of service on or after April 1, 2023

Rocky Mountain Health Plans (RMHP), a UnitedHealthcare company, appreciates your patience with the transition of our claims processing systems that began on January 1, 2023.

We are here to help

If you have questions, please reach out to your RMHP Provider Relations Representative, or call the following Provider Services phone number based on the specific plan in question:

UnitedHealthcare Individual and Family Plans
888-478-4760

UnitedHealthcare D-SNP
800-701-9054

UnitedHealthcare Community Health Plans
(CHP+)
877-668-5947

UnitedHealthcare Community Health Plans
(Medicaid PRIME/RAE)
877-421-6204

UnitedHealthcare Medicare Advantage
877-842-3210

Read all communications you receive from UHC and RMHP. Read the most recent Frequently Asked Questions (FAQ). This FAQ will be updated regularly. Please bookmark and check this link often for new and updated information throughout the transition.

NEW! On-Demand Annual Care Visit Course

Need a refresher or want more information on HCC & CPT II coding components that occur at annual care visits (ACVs)? ACVs, also known as annual wellness visits or annual comprehensive physicals, are a critical component to preventing illness and delaying the progression of diseases while supporting healthy behavior change. Conducting regular ACVs offers great opportunities to improve the quality of care, identify care gaps, and help create a personalized prevention plan.

Take this 20-minute course to learn how to optimize your ACVs today!

Population Health Focus: Diabetes Focused Visits in Primary Care

According to the American Diabetes Association (ADA, 2018), approximately 34.2 million Americans, or 10.5% of the population, live with diabetes. 1.6 million children and adults have type 1 diabetes. Roughly 1.5 million Americans are newly diagnosed with diabetes per year, and diabetes remains the 7th leading cause of death in the US. Most patients with diabetes seek care for this chronic condition from their primary care providers (PCP).

Recognizing the burden on PCPs on the front lines of diabetes care, the ADA has developed the accredited professional education program, Diabetes Is Primary (DIP). DIP is based on the ADA's Standards of Medical Care in Diabetes (SOC) – the gold standard in diabetes treatment. These guidelines, updated annually, ensure that patients receive up-to-date, evidence-based care. Included in the guidelines is the importance of cardiovascular disease (CVD) and chronic kidney disease (CKD) risk management for patients with diabetes as well as strategies to address obesity, weight management, retinopathy, neuropathy, and foot care.

The complexity of diabetes management and the implications for morbidity and mortality without treatment warrant the need for the practice have a comprehensive diabetes management program in place. This includes the opportunity to standardize the components of the diabetes focused visit. Interval visits should occur at least every 3 – 6 months individualized to the patient based on glycemic control, comorbidities, and additional risk factors. Consider using your care team and a diabetes visit template to aid in agenda setting for this visit. Use this visit as an opportunity to partner with your patient on the management of their diabetes and to educate them to the why behind the numbers. Additionally, ensure patients with diabetes have an encounter (in-person or telehealth) after any emergency department visit or hospitalization. Transitions of care processes are critical to reduce readmissions and promote positive outcomes.
The following components outlined by the CDC and the ADA should be included in a diabetes visit template.

Click on the links below to learn more about the coding and billing best practices.

Visit components	Rationale	Frequency
Review of current medications	Studies have shown that 20% to 30% of medication prescriptions are never filled and about 50% of medicines for chronic diseases are not taken as prescribed (at the correct time or dose or in relation to eating). Conducting comprehensive reviews of medicines and educating patients to the importance of taking medications as prescribed can improve glycemic control. Consider writing prescriptions for 90-day refills to help improve adherence, where clinically appropriate.	Every visit
A1c test, review of BG log	Discuss with patient how blood glucose levels translate to A1c and review the importance of "time in range" to reduce long term complications of diabetes.	Every 3-6 mo.
Assessment of CKD including eGFR and microalbumin	Diabetes and hypertension are the leading causes of CKD. Approximately 1 in 3 adults with diabetes could also have CKD. CKD can progress to end-stage renal disease (ESRD) requiring dialysis or kidney transplant.	Annually

Assessment for retinopathy	Eye diseases that can affect people with diabetes include diabetic retinopathy, macular edema (which usually develops along with diabetic retinopathy), cataracts, and glaucoma. Diabetic retinopathy is the most frequent cause of new cases of blindness among adults aged 20-74 years.	Annually
Assessment for neuropathy	About half of all people with diabetes have nerve damage. This damage puts you at risk for developing foot ulcers that could get infected and not heal well. Foot ulcerations and amputations are common complications associated with diabetes.	Low risk: annually moderate risk: every 3-6 mo.
Assessment of ADCVD risk	Common conditions coexisting with type 2 diabetes (hypertension and dyslipidemia) are clear risk factors for ASCVD. For prevention and management of both ASCVD and hear failure, cardiovascular risk factors should be reviewed and addressed to reduce ASCVD for patients with diabetes.	Annually
Assessment of hypoglycemia risk	Severe hypoglycemia is associated with reduced cognitive function and those with poor cognitive function have more severe hypoglycemia. Hypoglycemia increases risk for emergency department visits and hospitalizations.	Annually
Development of self-management education and support	All people with diabetes should participate in diabetes self-management education and support to facilitate the knowledge, decision-making, and skills mastery for diabetes self-care. This referral should be made annually or during transitions of care or changes in health status occur.	Annually
Assessment for psychological well-being	Psychosocial screening and care when indicated should be provided to all people with diabetes and connection to behavioral health professionals for further assessment when symptoms of diabetes distress, depression, anxiety, etc. are recognized.	Every visit
Supporting positive health behaviors	Behavioral strategies should be used to support diabetes self-management and engagement in health behaviors to promote optimal diabetes health outcomes. Click on the links below to view in-language patient education on Healthy Eating Plate Tools: • Chinese (Simplified) • Chinese (Traditional) • English • Spanish	Every visit

Want to learn more? Take these OptumHealth Education™ courses and earn FREE CEUs. Credit hours are available for clinicians, dieticians, behavioral health providers, pharmacists, nurses, and care managers.

- Type 2 Diabetes: What's New?
- Threading The Needle: Practical Considerations In The Modern, Evidence-Based Management Of Type 2 Diabetes
- Diabetic Kidney Disease: Improving Outcomes and Reducing Costs

Colorado Department of Healthcare Policy & Financing (HCPF) Corner

COLORADO
Department of Health Care Policy & Financing

Please refer to the Colorado Department of Health Care Policy & Financing Provider News & Resources newsletter for any additional information.

Did you know? The Provider Portal has Moved!

Providers are reminded to update the existing bookmarks with the new URL.

Featured Quick Guide: Verifying Member Eligibility (Including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay
The Quick Guide was updated to display the **difference** between coverage under the Family Planning (FAMPL) benefit and the Emergency Medical and Reproductive Health Program (EMS).

Refer to the Verifying Member Eligibility Quick Guide to review the updated information in Step 6:

FAMPL

- The updated screenshot displays benefit details for a member covered by the FAMPL benefit. A member with FAMPL is eligible for family planning services or family planning-related services when the intent of the service is to delay, prevent or plan for a pregnancy.

Emergency Medical Services (EMS)

- The updated screenshot displays benefit details for a member covered by EMS. EMS is a limited benefit that covers both emergency and family planning services.

Visit the Quick Guides web page to locate all published Provider Web Portal Quick Guides.

Revalidation Reminder

Providers are reminded of the requirement to submit revalidation applications according to their scheduled due date. Claims may be denied or suspended if revalidation has not been completed.

Visit the Revalidation web page and refer to the Provider Revalidation Dates Spreadsheet.

Enrollment License Requirements and License Panel Updates

Current Health First Colorado providers that are required to maintain a license as part of their enrollment will receive a letter from the Department when the primary license is approaching expiration or has reached its expiration date.

Providers are reminded that Health First Colorado enrollment may be inactivated if the provider's license, certification, or accreditation has expired or is subject to conditions or restrictions. Refer to the May 2022 Provider Bulletin (B2200478) for more information.

Opioid Treatment Providers: Take-Home Buprenorphine

Effective May 1, 2023, opioid treatment providers (OTPs) may dispense up to a seven-day supply of take-home oral buprenorphine and buprenorphine combination products to a Health First Colorado (Colorado's Medicaid program) member as outlined within this policy.

Policy will allow for up to a seven-day, take-home supply of oral buprenorphine and buprenorphine combination physician-administered drugs (PADs) to be billed through the medical benefit via standard buy-and-bill processes when an OTP:

- Obtains the appropriate DEA registration
- Has authority based on the rules and regulations set forth by the State of Colorado
- Follows all guidelines set forth by the Substance Abuse and Mental Health Services Administration (SAMHSA)

Refer to the email, Opioid Treatment Providers: Take-Home Buprenorphine - 04-03-2023, for more information.

Reminder: Integrated Behavioral Health Care Grant Application Due April 26, 2023

The Integrated Care Grant Program's Request for Applications (RFA) was released on **March 22, 2023**. House Bill (HB) 22-1302 passed in May 2022 with the goal of supporting, improving and expanding integrated behavioral health services in Colorado. The legislation appropriated $31 million toward this task with most of these funds going directly to providers to expand access to integrated behavioral health services.

Through this grant program, funding is being offered for physical and behavioral health care providers. These providers will expand access to care and treatment for mental health and substance use disorders using an evidence-based integrated care model. Visit the Integrated Care Grant web page for more grant information. Visit the ARPA Grant Opportunities web page to review the RFA. Contact hcpf_integratedcare@state.co.us with any questions.

Federally Qualified Health Center (FQHC) Providers

Updated Rule Definition of a Supervised Encounter at FQHCs

The definition of a supervised encounter at FQHCs has been updated, effective September 30, 2022. The amended rule adds a candidate permit as a clinical social worker candidate (SWC) to the supervised provider types that can generate a billable encounter. Supervised visits with SWCs will be paid as encounters to FQHCs using the prospective payment system.

The updated rules can be found under 8.700.1.B.1 of the Department Program Rules and Regulations web page. Contact Morgan Anderson at Morgan.Anderson@state.co.us with any questions.

Physician Services, FQHC and Rural Health Center (RHC) Providers

Well Child Check-ups Via Telemedicine Update

Temporary coverage of well child check-ups provided via telemedicine were added during the federal Public Health Emergency for COVID-19. Telemedicine coverage of well child check-up codes will be discontinued, effective May 12, 2023. This end date aligns with the expiration of the federal PHE for COVID-19.

Procedure codes affected by this update include 99382, 99383, 99384, 99392, 99393 and 99394.
Providers will still be reimbursed for in-person well child check-ups. Visit the Telemedicine - Provider Information web page to find an updated list of telemedicine codes. Contact Morgan Anderson at Morgan.Anderson@state.co.us and Naomi Mendoza at Naomi.Mendoza@state.co.us with any questions.

General Updates for Durable Medical Equipment (DME) Providers

Continuous Glucose Monitors (CGMs)

Covered Durable Medical Equipment (DME) procedure codes can be found in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Billing Manual. The policies of the Department apply to these codes and the individual devices that are described by each code. The DMEPOS benefit does not include or exclude specific brands, makes and/or models when medical necessity can be determined.

There is a published list of covered continuous glucose monitor (CGM) products to provide better clarity for this benefit. This list will be updated to include the Dexcom G7, which uses procedure code E2103 for coverage. This list should always be used as a reference. It is not to be used for automatic approval or denial of a requested product.

The DMEPOS Billing Manual has also been updated to include a policy for CGM upgrades.

An upgrade to a new model or different brand of CGM may be deemed medically necessary in the following situations:

- There is documentation that the current device is no longer functional either partially or entirely, and therefore is no longer clinically effective, *or*
- The requested upgrade is different in its capability and would be expected to provide better clinical outcomes than the current device, *and*
- The member has been using their current device for at least three (3) years.
- If the current CGM requires repair or replacement that is no longer possible because it is obsolete, requests may be approved in cases where use is less than three (3) years. Prior Authorization Requests (PARs) may be pended to gather additional details regarding the device being obsolete.
- All requests must meet the definition of medical necessity as stated in 10 CCR 2505-10 8.076.8.

Obstetrics and Maternity Healthcare Providers

Revised Obstetrical Global Billing Requirements

Billing globally covered Obstetrics (OB)/Maternity service codes will require coding inclusions to identify prenatal (PN) and postpartum (PP) care visits and the dates PN and PP services were provided, effective June 1, 2023. The Centers for Medicare & Medicaid Services (CMS) is requiring agencies to report PN and PP care as a tool to monitor and help improve the quality of healthcare and health outcomes. A new claims system billing methodology has been developed to comply with CMS reporting which will enable providers to report provision of these critical services and to supply critical information to maximize quality maternal healthcare services for Health First Colorado (Colorado's Medicaid program) members during pregnancy.

This OB/Maternity billing change will be required and enforced for all Fee-for-Service (FFS) providers submitting professional claims.

It is recommended that FQHC and RHC providers follow these new billing guidelines to identify PN care visits when billing for labor and delivery (L&D) services (outside the normal encounter rate billing methodology) to accurately capture provision of these important healthcare services and quality healthcare metrics. It is recommended to include the Common Procedural Terminology (CPT) Category II PP visit code (0503F) on the regular encounter visit claim form to capture and identify these important PP care visits.

OB/Maternity care providers should continue to bill the most accurate Global or Bundled/Partial or Individual Maternity/OB CPT codes (59400 – 59622) applicable to their provision of maternity care services. Using one of the listed CPT Category II codes to identify and document each PN and PP visit will be the new required change in the obstetrical billing methodology. The CPT Category II codes need to be added to the same global/partial maternity billed claim, **or** if only the PN or PP visits are provided (when billing the global/partial codes are not appropriate), the CPT Category II PN and PP codes should be included on those individual PN (using CPT codes 59425 or 59426) or PP (using CPT code 59430) claims.

The identified CPT Category II "F" codes (0500F, 0501F, 0502F or 0503F) are utilized for descriptive and reporting purposes only and will not affect the claim reimbursement in any way.

Providers will need to document PN and/or PP visits on separate claim lines below the identified maternity-related (global, partial or L&D) CPT code by including:

1. The appropriately described CPT Category II code documenting the PN or PP care visit, ***and***
2. The date of service (DOS) for each of the PN and PP visits.

The claims system will identify these listed CPT Category II codes with their associated dates of service as a "no-charge" line item.

The following CPT Category II "F" codes are required to identify and document service provision for each PN and PP care visit:

Use either 0500F OR 0501F as the descriptive code for the first (initial) PN visit:

- 0500F
- 0501F
- 0502F
- 0503F

Billing Example: If the same provider who rendered the L&D also rendered antepartum (minimum of four visits) and PP care (at least one visit), the provider must report:

1. The appropriate Global OB Care code associated with the date of delivery (example: 59400 listed on claim line 1), ***and***
2. The antepartum CPT Category II descriptive codes (minimum of four visits) (example: 0500F or 0501F reported on line 2 and 0502F reported [at a minimum] on lines 3, 4 and 5), ***and***
3. The PP CPT Category II descriptive code (minimum of one visit) (example: 0503F on line 6), ***and for each identified CPT Category II code listed, also include***
4. The dates the antepartum and PP visits were rendered.

All codes should be reported on the same claim.

Refer to the recently published Special Provider Bulletin – Obstetrics and Maternity Healthcare (B2300492), which can be viewed on the Bulletins web page. This special bulletin contains additional information related to these changed OB billing requirements. The Obstetrical Care Billing Manual will be updated with the revised OB billing information.

Contact Melanie Reece at Melanie.Reece@state.co.us with additional questions regarding these changes in Global OB/Maternity service code billing and the required billing changes to include CPT Category II codes for identifying provision of PN and PP care visits. Contact the Provider Services Call Center with billing questions.

Medicaid/CHP+ Continuous Coverage Unwind Corner

Colorado has started renewal determinations beginning with those members who have a renewal in May 2023. This is coming after a three year pause of redetermination processes in accordance with a **federal action mandate**. Starting in March, the Department of Healthcare Policy and Financing (HCPF), in collaboration with their county partners, began sending renewal notices to members whose renewal anniversary is in May. This process will continue month by month through April 2024 to re-determine the eligibility status of all 1.78 million Medicaid and CHP+ members.

Many members will be auto-renewed through an ex parte process, approximately one-third of the population, which means they will not need to take any action to stay covered. The remainder will need to take some type of action to stay covered. Members will either be mailed a renewal packet or will receive notification through their PEAK account. A new part of this process is that Members must sign and return their paperwork by the deadline listed on their renewal.

You can help by encouraging members to sign up for emails and texts so the State can reach them with important Medicaid and CHP+ renewal messages. Additionally, you can help educate patients who have Medicaid by downloading and printing the attached print materials in your offices, lobbies, or clinics.

- Flyer - English
- Table tent - English / Spanish
- Poster – English / Spanish

We appreciate your help in ensuring our Medicaid and CHP+ members stay covered! If you have any questions, please email RAE support at raesupport@uhc.com

Keep your Medicaid or CHP+ coverage

RMHP Language Line Services Available

Annually, RMHP assesses the languages spoken by Members to meet the needs of people and communities who speak languages other than English. In 2022, RMHP identified Members who spoke: Albanian (Tosk), American Sign Language, Arabic, Armenian, Burmese, Chinese, Danish, Italian, Japanese, Korean, Persian, Polish, Portuguese, Romanian, French, German, Greek, Hebrew, Hindi, Hungarian, Indonesian, Russian, Samoan, Spanish, Tagalong, Thai, Turkish and Vietnamese. Of these languages, Spanish and Chinese were the most prevalent with an estimated 20,000 Members speaking Spanish and over 100 Members speaking Chinese in 2022 and similar estimates in 2021. This data is derived from enrollment files and self-reported information collected. These are estimates, and RMHP believes language may be under reported.

To ensure Members can communicate with their care teams and understand vital healthcare information, RHMP provides access to Language Line for providers caring for RMHP Members. If your office is unable to accommodate language service requests, RMHP Language Line is available. To access this service, call Member Services at:

- Individual & Family Plans (Marketplace): 888-809-6539
- PRIME, RAE, CHP+: 800-426-6204
- Medicare Advantage: 800-980-5195
- Dual Special Needs Plan (DSNP): 855-495-3727

Resources

- Health Literacy Universal Precautions Toolkit: Addressing Language Differences
- Effective Communication Video Series by Colorado-Cross Disability Coalition
- Online Guide to Providing Effective Communication and Language Assistance Services
- Cultural Competence and Patient Safety: Interview with Cindy Brach
- Patient Resources: Search by Language and Download

Medicaid Dental Visit Coverage Reminder

To keep children's teeth healthy, the Medicaid program allows for certain preventive dental visits and treatments every year. These visits can be for checkups to keep a child's teeth and gums healthy or for treatment.

Health First Colorado Members have a dental benefit. Dental Services through DentaQuest include: Services include cleanings, fillings, root canals, crowns, and partial dentures. There are no co-pays applicable. There is no limit for children's services (21 years old and under). There are no exclusions. Sometimes a prior authorization is needed, check What is a Prior Authorization Request and why do I need one? - Health First Colorado to determine if a prior authorization is needed.

Resources

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) | Colorado Department of Health Care Policy & Financing
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Guidebook
- Colorado State Dental Plans | Medicare, Medicaid, CHIP Dental Insurance - DentaQuest
- Colorado Health Plans | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans (uhccommunityplan.com)

Education & Training

Register today for the 2023 Monthly Webinar!

The RMHP Quality Department hosts monthly webinars for primary care practices and providers. Topics for this monthly informational webinar, *Clinical Quality Improvement Newsroom*, includes value-based contracting updates and discussion, clinical topics, RMHP program updates, & more! Join us monthly on the 4th Thursdays from 12:15-1:00PM. Register here! Questions? Please reach out to Rachael Biller at Rachael.Biller@uhc.com.

Chronic Kidney Disease ECHO® Series

Join a free webinar series to learn more about chronic kidney disease. Participants can earn 1.0 CME/CEUs per session.

Curriculum topics will include:

- Screening and diagnosis of chronic kidney disease (CKD), overview of diagnosis, disparities at local level
- SGLT2 inhibitors and GLP-1 agonists in CKD and diabetes
- Hypertension screening and management and its relationship to CKD
- Diabetes management: education and support
- When and how: referral to nephrology and how to co-manage patients
- Insulin management in patients with CKD and diabetes
- Management of CKD complications and dialysis patients
- Lifestyle management in chronic disease
- Patient activation and health literacy

Kicks off Tuesday, April 25, 2023 at 12-1 p.m. CST. Sessions will take place every other Tuesday at 12-1 p.m. CST or Thursday at 1-2 p.m. CST. Register here.

Text Tips!

Optum has a new program that allows you to receive text tips related to coding, quality, and documentation on your mobile device. You will receive 2-3 texts per week on Tuesday-Thursday. Standard text messaging rates apply based on your mobile plan. You may choose to opt out of the program at any time by texting back the word Stop. If you need assistance, please email Risk.Education@optum.com For questions and/or assistance on the program please contact CDQ.Tips@optum.com. Click here to register.

Provider Role in Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Health Outcome Survey (HOS) Results

Your interactions with your patients play a key role in their experience and overall health. And your guidance helps them navigate the complex world of health care so they can get timely treatment. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Health Outcomes Survey (HOS) help provide feedback on your patients' experience. CAHPS surveys will be sent to select patients starting in **February 2023** reflecting on their experiences with the health care system in 2022.

This checklist contains suggestions on discussing key topics with patients. Implement today to help improve patient experience! **As a reminder, if you are a primary care practice with a RMHP RAE or RMHP Advanced Payment Model (APM) value-based contract, CAHPS scores impact your payment tier. Connect with your RMHP Clinical Program Manager for more tips on improving patient experience.**

Optum Health Education™

Did you know that OptumHealth Education™ offers free clinical education and CMEs? There are on-demand courses and live sessions. Create a free account and get started today by clicking here!

Featured Sessions:

EMPATHY: SOCIAL CARE EDUCATION

The empathy series is designed to equip you with social care expertise that drives deeper awareness and compassionate care for the people you serve. This content is applicable to any role within health care, focusing on critical concepts like health equity, social determinants of health, empathy, health disparities, cultural humility, motivational interviewing and compassion.

This series will require you to reflect on your personal and cultural experiences and encourage you to slow down, actively listen and take the appropriate action to serve others, whether that be patients, colleagues, family, friends or your community.

Click here to take the activity.

THE RELATIONSHIP BETWEEN OBESITY & COVID-19

This activity will provide an overview of the relationship between obesity and COVID-19. Participants will also learn about the risk factors and health disparities pertaining to obesity and COVID-19.

Click here to take the activity.

RMHP Coder Biller Networking Group

Do you want to benefit from combined knowledge and experience through support and education? RMHP is providing a virtual space for you to network, learn and share best practices. Meetings are being held quarterly and with monthly newsletter distribution. The next meeting is scheduled for March 21, 2023 from 12:00-1:00 PM. View the January newsletter here where you will find questions from peers, education and resources on a chosen measure of the month. To register, email Shanteal.Bucholz@uhc.com.

Risk Adjustment and Hierarchical Condition Coding (HCC) Resource for You: Diabetes

Accurate and complete documentation of chronic condition diagnoses by clinicians is an essential component of the risk adjustment and the hierarchical condition category (HCC) process. Providers are required to document all conditions they evaluated during every face-to-face visit. It is also imperative that the documentation of a disease/condition be as specific as possible. Specificity can make a difference in the patient's treatment plans and reimbursement. Each month, Rocky Mountain Health Plans will provide a list of resources for providers to review at their pace. The goal is to improve education and understanding around risk adjustment, HCC coding and how RMHP can support you.

With diabetes presenting as one of the most prevalent chronic diseases in the United States, and Type 2 Diabetes impacting the health of millions of people, an immense financial and institutional burden is placed on the economy and healthcare institutions. Many providers document with adequate accuracy for medical care but are unaware of the details needed for accurate code selection for billing, reimbursement, and quality measures.

• Diabetes with Complications • Diabetes with Ophthalmic Complications • Diabetic Dyslipidemia	Diabetes Codes	DM Complications Document FAQs	DM Telehealth Job Aid
Handouts related to documentation of common diabetic chronic complications. Diabetes Mellitus, diabetic, DM, NIDDM, T2D, T2DM, Adult-onset	Handout with common type 2 diabetes codes and related complications. Diabetes Mellitus, diabetic, DM, NIDDM, T2D, T2DM, Adult-onset	FAQs related to diabetes with chronic complications. Diabetes Mellitus, diabetic, DM, NIDDM, T2D, T2DM, Adult-onset	FAQs related to diabetes with chronic complications. Diabetes Mellitus, diabetic, DM, NIDDM, T2D, T2DM, Adult-onset

DIABESITY: A CALL FOR URGENT ACTION	Optum Risk Adjustment Coding Standards	Risk Adjustment Presentation Recording
Earn 1 FREE CEU credit by attending this webinar. This activity will highlight new updates in our understanding of how diabesity develops and describe the negative physiologic effects of this disease on multiple body systems, notably the cardiovascular and renal systems.	This extensive resource provides a summary of coding standards for the Medicare Advantage population.	This 14-minute video reviews risk adjustment, HCC and the importance of accurate documentation.

At RMHP, we are dedicated to working with you to help our Members receive the best care possible. Thank you for your commitment to providing quality care. We value your partnership, and hope you enjoy this monthly resource!

www.rmhp.org