RHC Care Management Services for 2025

May 6, 2025

Oregon State Office of Rural Health

CARE MANAGEMENT SERVICES

New coding, guidelines and reimbursement for 2025

CARE MANAGEMENT SERVICES

- Major Changes in how Care Management Services will be coded.
- Still reported on the Medicare UB-04/837I
- No G0511 umbrella code after June 30, 2025.
- Individual care management codes will be reported and each paid at a fee for service amount.
- Addition of Advanced Primary Care Management Codes for FFS and RHCs. These codes will identify the acuity and intensity of care management services. The new codes will be stratified into three levels based.
- **Coding changes will not take effect until July 1, 2025** to give CMS, MACs and RHCs to configure systems and implement payment rules.
- Add-on codes will be allowed for RHC billing of care management services.
- RHCs not required to report MIPS will not be required to report the performance measures mandated for primary care management.

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12958	**Date: November 8, 2024**
	Change Request 13581

SUBJECT: Updates to Billing for Care Coordination Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for dates of service on or after January 1, 2025.

https://www.cms.gov/files/document/r12958otn.pdf

B. Policy: Effective for services furnished on or after January 1, 2025, RHCs and FQHCs shall bill the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS G0511. However, we are permitting a delay in compliance of this requirement for 6 months at least until July 1, 2025, for RHCs and FQHCs to update their billing systems if necessary. During the 6-month delay (January 1, 2025 – July 1, 2025), RHCs and FQHCs may continue to bill HCPCS G0511for care coordination services, after which they will be required to bill the individual HCPCS codes.

RHCs and FQHCs that do not need to update their billing systems shall bill the individual CPT/HCPCS codes for care coordination services. RHCs and FQHCs shall determine on a facility level basis whether they are continuing to bill G0511 or the individual HCPCS codes and not by a claim by claim or patient by patient basis.

Since the APCM services are not included in G0511, when furnishing APCM, RHCs and FQHCs shall report G0556, G0557, G0558 as appropriate effective January 1, 2025.

The rates are updated annually based on the PFS amounts. For RHCs, beneficiary deductible and coinsurance apply. For FQHCs, beneficiary coinsurance applies.

Care coordination services that can be furnished and paid separately in RHCs and FQHCs effective January 1, 2025:

Care Coordination Services in RHCs and FQHCs

We are finalizing several changes related to reporting care coordination services in RHCs and FQHCs to better align payment to RHCs and FQHCs for these services with other entities furnishing similar care coordination. Specifically, we are finalizing with a modification to our proposal, a policy that, starting in 2025, RHCs and FQHCs will report the individual CPT and HCPCS codes that describe care coordination services instead of the single HCPCS code G0511. We are also allowing for a transition period of six-months, to at least until July 1, 2025, to enable those RHCs/FQHCs to be able to update their billing systems. We are also finalizing a policy that permits billing of the add-on codes associated with these services. This will improve payment accuracy for RHCs and FQHCs when furnishing these services and will allow beneficiaries to better understand which services (generally not furnished face-to-face) they are receiving. For 2025, we are also adopting the coding and policies regarding APCM services for RHC and FQHC payments. Under these finalized rules, payments to RHCs and FQHCs would be made at the national, non-facility, PFS amounts when the individual code is on an RHC or FQHC claim, either alone or with other payable services and payment rates. We would pay for these services in addition to the RHC All-Inclusive Rate (AIR) or FQHC prospective payment system (PPS). Payment rates would be updated annually based on the PFS amounts for these codes. RHCs and FQHCs, not eligible for MIPS, are not required to report the Value in Primary Care MVP to meet the performance measurement requirement.

- RHCs may bill HCPCS code G0511 multiple times in a calendar month for the codes listed in the table below as long as they've met all requirements and there isn't double counting. For example, RHCs can bill HCPCS code G0511 twice for 20 minutes of qualifying CCM services and 30 minutes of qualifying PCM services, as long as the clinical staff minutes don't overlap.

General Care Management Services	HCPCS/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484

General Care Management Services	HCPCS/CPT Codes
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023
PIN-PS	G0140

Until 7/1/25

G0511**
$54.67*

**Using G0511 is allowed until7/1/2025, then the codes for the specific service will be required.

*Subject to sequestration reduction.

National Fee for Service Reimbursement

On or before 7/1/25

98975	Rem ther mntr 1st setup&edu	$	19.73
98976	Rem ther mntr dev sply resp	$	43.02
98977	Rem ther mntr dv sply mscskl	$	43.02
98980	Rem ther mntr 1st 20 min	$	50.14
98981	Rem ther mntr ea addl 20 min	$	39.14
99091	Collj & interpj data ea 30 d	$	51.75
99424	Prin care mgmt phys 1st 30	$	80.87
99425	Prin care mgmt phys ea addl 30	$	58.87
99426	Prin care mgmt staff 1st 30	$	61.78
99427	Prin care mgmt staff ea addl 30	$	50.46
99437	Chrnc care mgmt phys ea addl 30	$	57.58
99439	Chrnc care mgmt staf ea addl 20	$	45.93
99453	Rem mntr physiol param setup	$	19.73
99454	Rem mntr physiol param dev	$	43.02
99457	Rem physiol mntr 1st 20 min	$	47.87
99458	Rem physiol mntr ea addl 20	$	38.49

National Fee for Service Reimbursement

99474	Self-meas bp 2 readg bid 30d	$ 16.50
99484	Care mgmt svc bhvl hlth cond	$ 53.05
99487	Cplx chrnc care 1st 60 min	$ 131.65
99489	Cplx chrnc care ea addl 30	$ 70.52
99490	Chrnc care mgmt staff 1st 20	$ 60.49
99491	Chrnc care mgmt phys 1st 30	$ 82.16
G0019	Comm hlth intg svs sdoh 60 mn	$ 77.96
G0022	Comm hlth intg svs addl 30 m	$ 48.52
G0023	Pin srv 60 min pr m	$ 77.96
G0024	Pin srv addl 30 min pr m	$ 48.52
G0071	Comm svcs by rhc/fqhc 5 min	$ 13.91
G0140	Nav srv peer sup 60 min pr m	$ 77.96
G0146	Nav srv peer sup addl 30 pr m	$ 48.52
G0323	Care manage beh svs 20mins	$ 53.70
G0511	RHC/FQHC 20min mo	$ 54.67
G0512	RHC/FQHC 60min mo	$ 139.41

National Fee for Service Reimbursement

NEW

G0556	Adv prim care mgmt lvl 1		$ 15.20
G0557	Adv prim care mgmt lvl 2	Not bundled with G0511 in 2025	$ 48.84
G0558	Adv prim care mgmt lvl 3		$ 107.07
G2025	Dis site tele svcs rhc/fqhc		$ 94.45
G3002	Chronic pain mgmt 30 mins		$ 80.22
G3003	Chronic pain mgmt addl 15m		$ 29.44

- Know the full CPT code descriptions
- It's easy to select the wrong code based only on the short description
- Know who can report the service
  - Provider
  - Clinical Staff
  - Auxiliary Staff
- Documentation is very important especially as we more away from some of the time-based codes.

- Remember that the vendor works for you.

Advanced Primary Care Management Services (APCM)

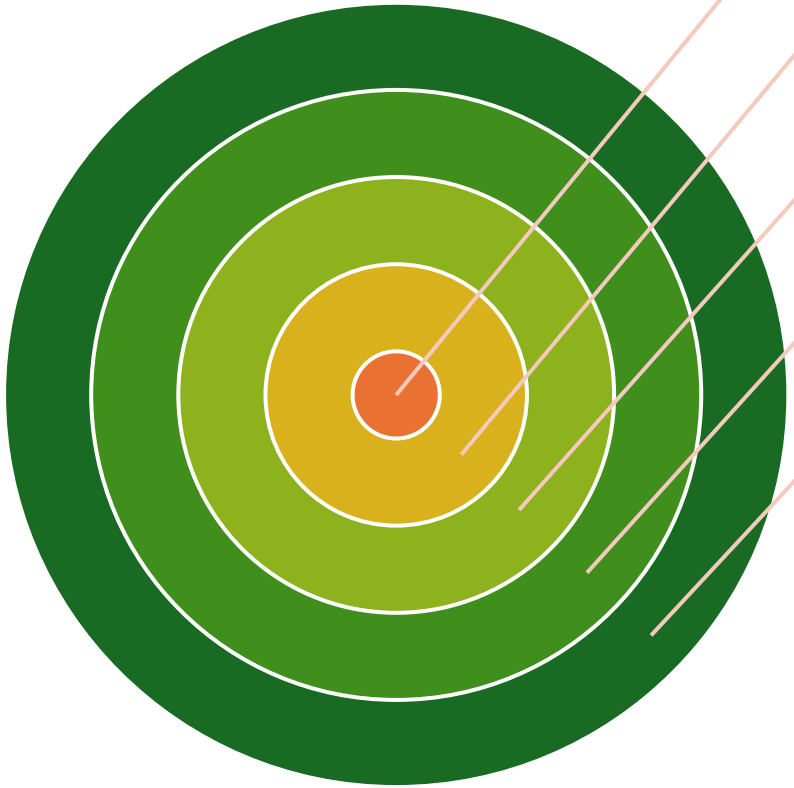
A strong foundational primary care system is fundamental to improving health outcomes, lowering mortality, and reducing health disparities, which is why the Department of Health and Human Services has been taking action to strengthen primary care, including establishing coding and payment for advanced primary care management services in the CY 2025 PFS final rule.

For CY 2025, we are finalizing our proposal to establish coding and payment under the PFS for a new set of APCM services described by three new HCPCS G-codes (G0556, G0557, G0558). The finalized APCM services incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management. However, unlike existing care management codes, there are no time-based thresholds included in the service elements, which is intended to reduce the administrative burden associated with current coding and billing. Instead, the new APCM codes are stratified into three levels based on an individual's number of chronic conditions and status as a Qualified Medicare Beneficiary, reflecting the patient's medical and social complexity.

Level 1 (G0556) is for persons with one chronic condition; Level 2 (G0557) is for persons with two or more chronic conditions; and Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary.

APCM

Basically, a Medical Home Model/ Team-based Care



Preventive Services

Chronic Care Management

Care Coordination

Population Health/Outcomes/Data

Primary Care

Although there is not a time requirement for APCM, these services are as comprehensive in nature than chronic care management.

NEW

G0556	Adv prim care mgmt lvl 1		$ 15.20
G0557	Adv prim care mgmt lvl 2	Not bundled with G0511 in 2025	$ 48.84
G0558	Adv prim care mgmt lvl 3	QMB Patients	$ 107.07

Level 1 (G0556) is for persons with one chronic condition;

Level 2 (G0557) is for persons with two or more chronic conditions; and

Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary.

ADVANCED PRIMARY CARE MANAGEMENT SERVICES (APCM)

- Principal Care Management, Transitional Care Management, and Chronic Care Management are combined
- Unlike existing care management codes, there are no time-based thresholds included in the service elements
- New APCM codes are stratified into three levels based on an individual's number of chronic conditions and status as a Qualified Medicare Beneficiary, reflecting the patient's medical and social complexity.
  - Level 1 (G0556) is for persons with one chronic condition; ($15.20)
  - Level 2 (G0557) is for persons with two or more chronic conditions; ($48.84)
  - and Level 3 (G0558) is for persons with two or more chronic conditions and status as a Qualified Medicare Beneficiary. ($107.07)

Advanced Primary Care Management (2025)

To bill for APCM services, you must complete these elements when they're clinically appropriate for the individual patient (you don't have to provide all of these services every month):

- **Get patient consent.** Get written or verbal consent from the patient to participate in APCM services, and document it in the patient's medical record. The consent must inform your patient that:
  - Only 1 provider can furnish and be paid for APCM services during a calendar month
  - They have the right to stop services at any time
  - Cost sharing may apply to the patient

  Get consent before you start APCM services. You only need to get consent once.
- **Conduct an initiating visit** (paid separately) for new patients. You don't need to conduct this visit if you or another provider in your practice have:
  - Seen the patient within the past 3 years
  - Provided another care management service (APCM, CCM, or PCM) to the patient within the past year

  The Medicare Annual Wellness Visit (AWV) may qualify as the initiating visit if the provider that will be responsible for providing APCM care performs the AWV

Advanced Primary Care Management (2025)

- **Provide 24/7 access and continuity of care,** including:
  - 24/7 access for your patients or their caregivers with urgent needs to contact you or another member of the care team
  - Real-time access to the patient's medical information
  - The ability for the patient to schedule successive routine appointments with a designated member of the care team
  - Care delivery in alternative ways to traditional office visits, like home visits or expanded hours
- **Provide comprehensive care management,** including:
  - Systemic needs assessments (medical and psychosocial)
  - System-based approaches to ensure receipt of preventive services
  - Medication reconciliation, management, and oversight of self-management

Advanced Primary Care Management (2025)

- **Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan.**
  - The care plan must be available within and outside the billing practice, as appropriate, to individuals involved in the patient's care
  - Members of the care team must be able to routinely access and update the care plan
  - You must also give a copy of the care plan to the patient or caregiver
- **Coordinate care transitions** between and among health care providers and settings, including:
  - Referrals to other providers
  - Follow-up after an emergency department visit
  - Follow-up after discharge from a hospital, skilled nursing facility (SNF), or other health care facility

  Coordination of care transitions must include:

  - Timely exchange of electronic health information with other health care providers

Timely follow-up communication (direct contact, phone, or electronic) with the patient or caregiver within 7 days of discharge from an emergency department visit, hospital, SNF, or other health care facility, as clinically indicated

Advanced Primary Care Management (2025)

- **Coordinate practitioner, home-based, and community-based care.** You must provide ongoing coordinating communication and documentation on the patient's psychosocial strengths, functional deficits, goals, preferences, and desired outcomes from practitioners, home- and community-based service providers, community-based social service providers, hospitals, SNFs, and others.
- **Provide enhanced communication opportunities.** You must:
  - Offer asynchronous, non-face-to-face consultation methods other than the phone, like secure messaging, email, internet, or a patient portal
  - Be able to conduct remote evaluation of pre-recorded patient information and provide interprofessional phone, internet, or electronic health record (EHR) referral services

Be able to use patient-initiated digital communications that require a clinical decision, like virtual check-ins, digital online assessment and management, and evaluation and management

(E/M) visits (or e-visits)

Advanced Primary Care Management (2025)

- **Conduct patient population-level management.** You must:
  - Analyze patient population data to identify gaps in care
  - Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
- **Measure and report performance,** including assessment of primary care quality, total cost of care, and meaningful use of Certified EHR Technology (CEHRT). You can either:
  - Report the Value in Primary Care MIPS Value Pathway (MVP). You'll report performance starting in 2026 for CY 2025. RHCs typically exempt from MIPS.

Participate in a Medicare Shared Savings Program Accountable Care Organization (ACO), Realizing Equity, Access, and Community Health (REACH) ACO, Making Care Primary model,

or Primary Care First model.

Care Management Element	Chronic Care Management	APCM
Patient Consent	✓	✓
Seen patient within 3 years/initiating visit	✓	✓
24/7 Access	✓	✓
Real time access to records	✓	✓
Needs Assessment/Data Analysis	✓	✓
Preventive Services	✓	✓
Care Plan (internal/external)	✓	✓
Coordination of Care	✓	✓
Offer messaging, email or portal communication	✓	✓
Transitional Care Management		✓
Clinical Documentation	✓	✓
Time Documented	✓	

POPULATION HEALTH DATA SOURCES

Data.CMS.gov
Centers for Medicare & Medicaid Services

Explore Data | View Tools | Browse by Category | About Us | Related Sites | API Docs

https://data.cms.gov/tools/mapping-disparities-by-social-determinants-of-health

Measure Selection

Year: 2020

State/Territory: Oregon

County: Please Select One

Census Tract: Please Select One

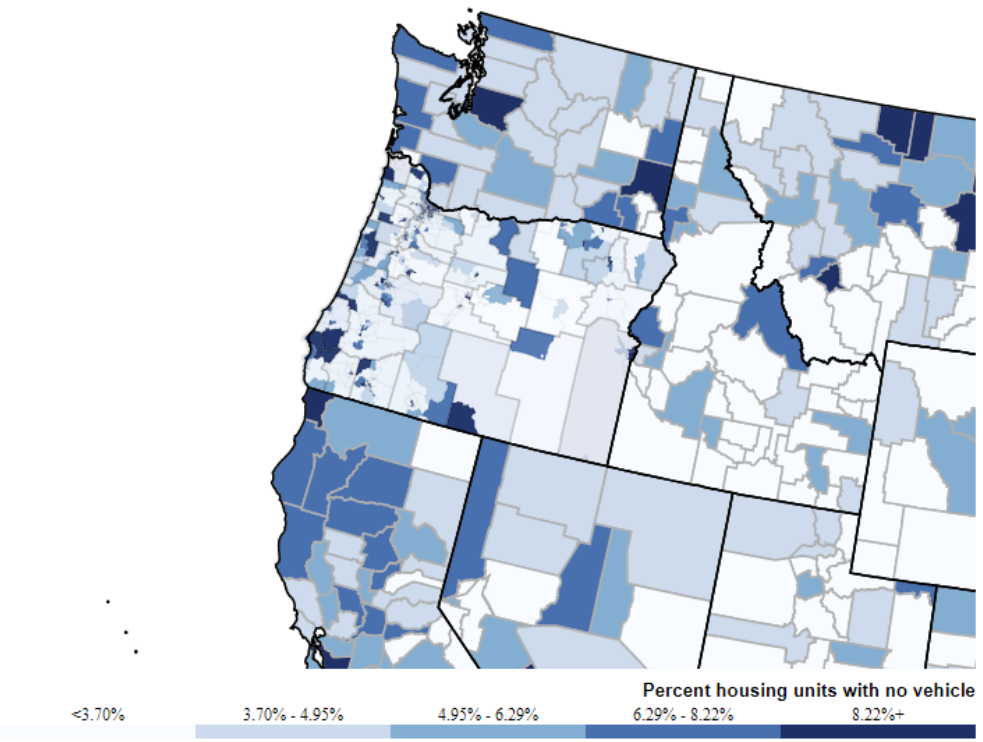
Domain: Social and Community Conte

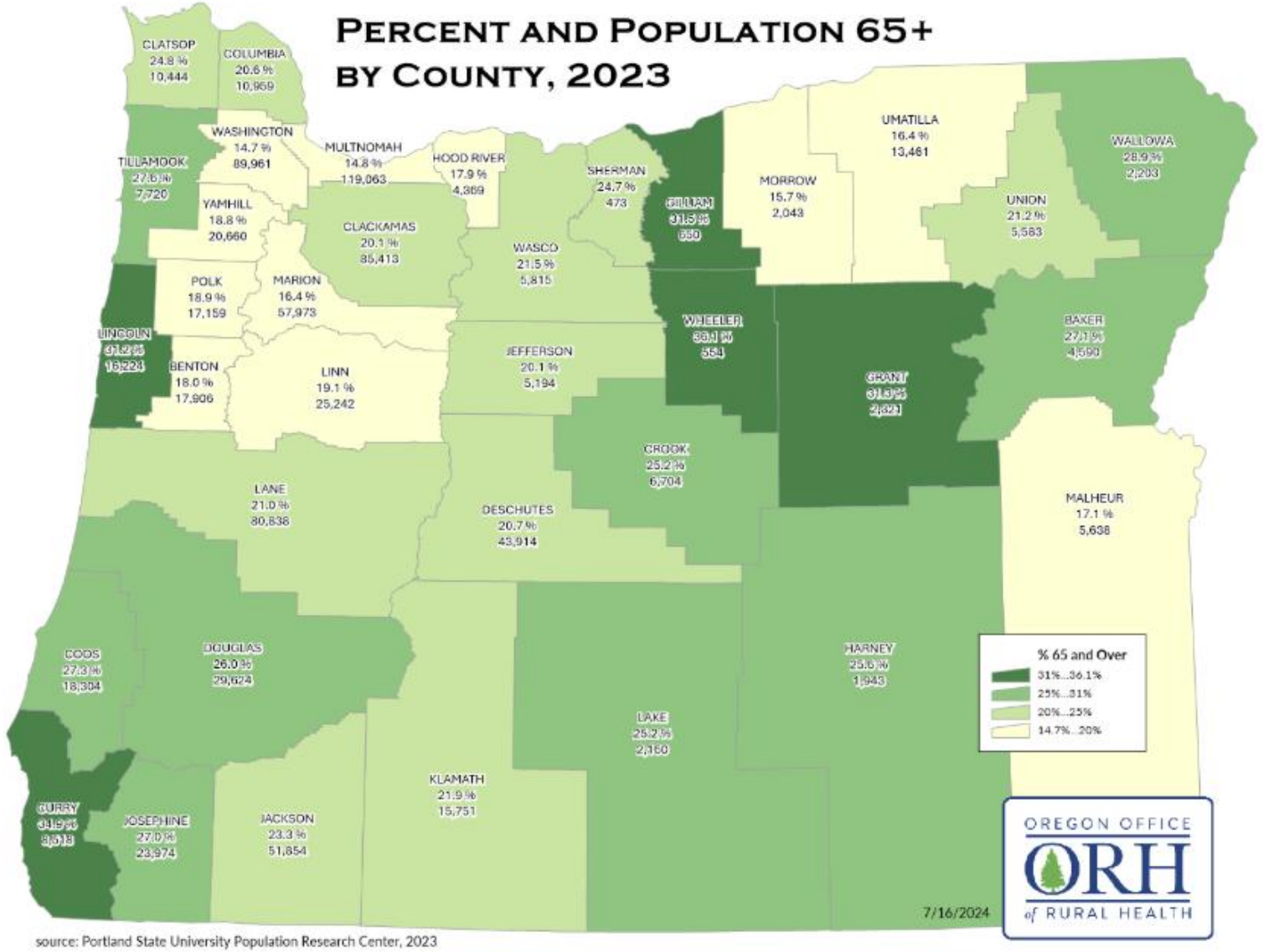
Measure: Percent housing units with nc

Download SDOH Data | Download Map

Geographic Selection

Hover over county or Census Tract to see data. To view Census Tract-level data, select a state and county.





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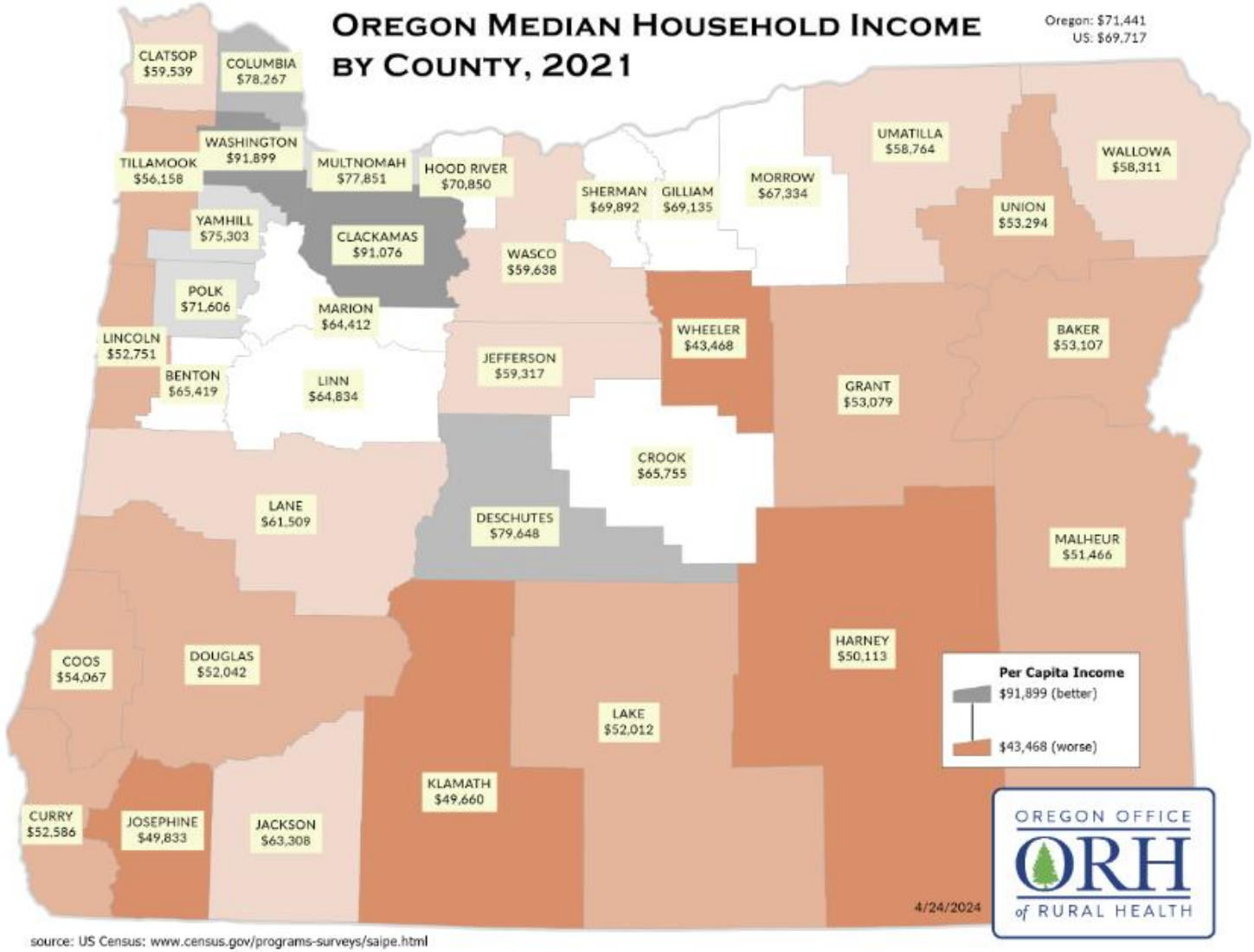

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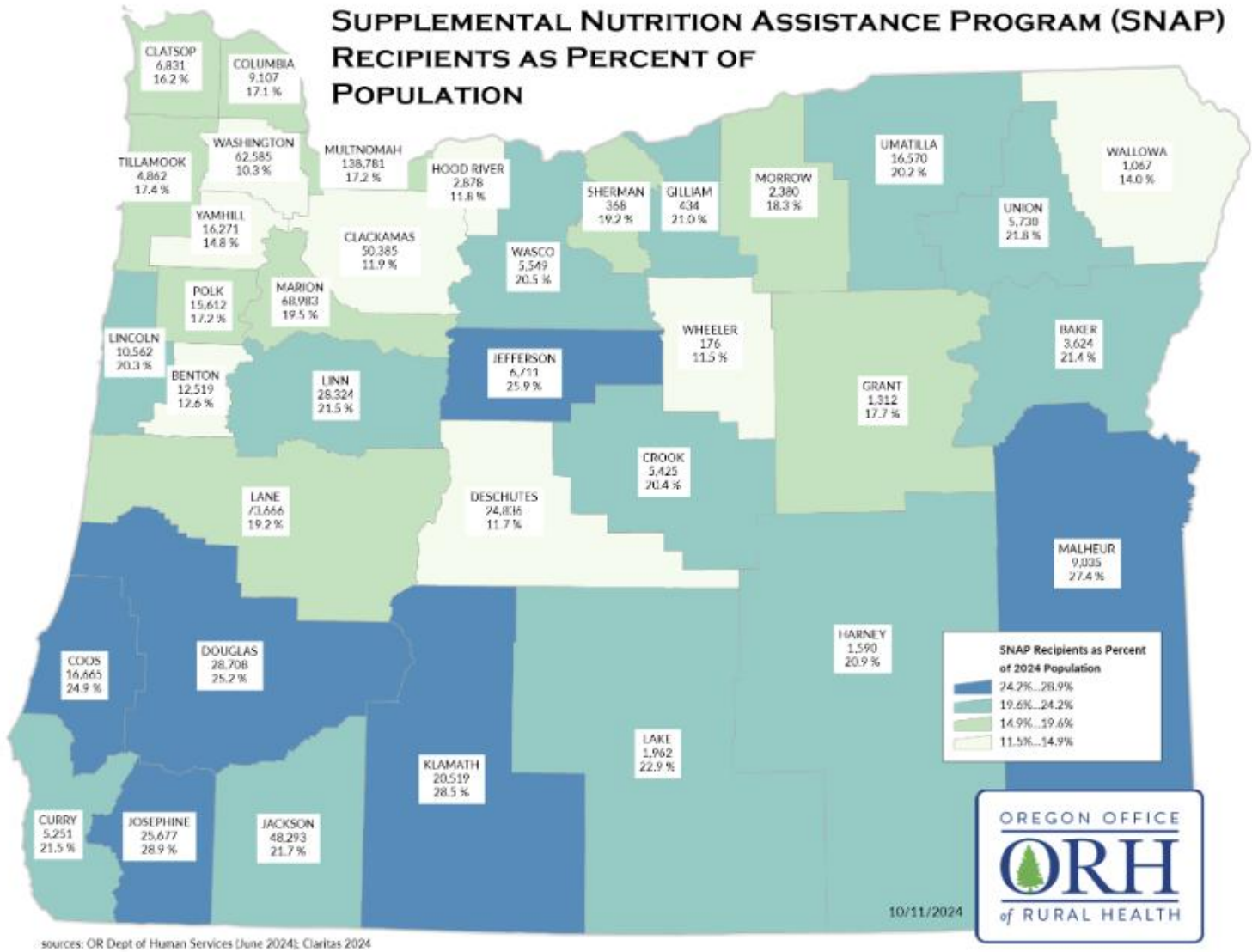

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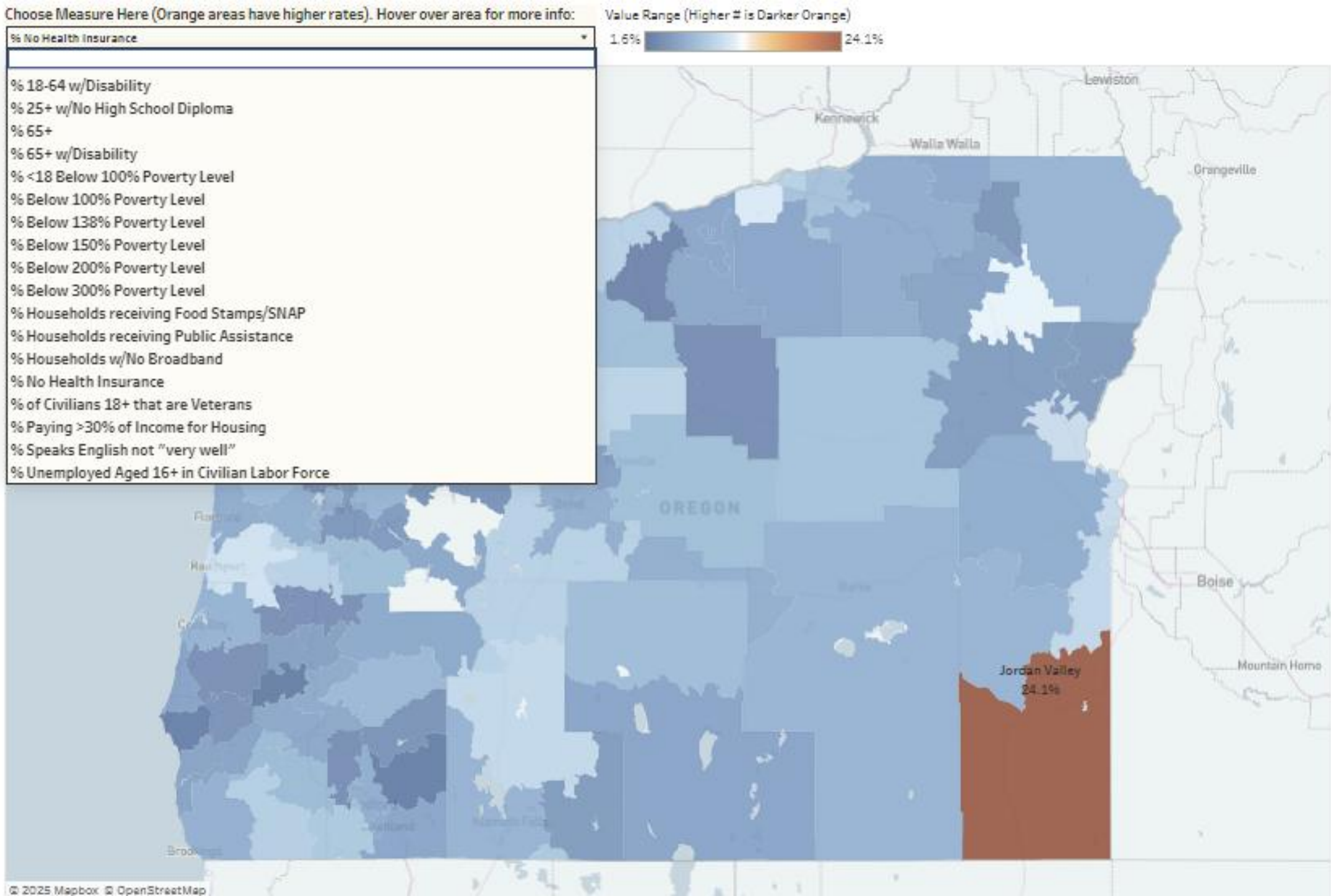
Choose Measure Here (Orange areas have higher rates). Hover over area for more info:
% No Health Insurance
% 18-64 w/Disability
% 25+ w/No High School Diploma
% 65+
% 65+ w/Disability
% <18 Below 100% Poverty Level
% Below 100% Poverty Level
% Below 138% Poverty Level
% Below 150% Poverty Level
% Below 200% Poverty Level
% Below 300% Poverty Level
% Households receiving Food Stamps/SNAP
% Households receiving Public Assistance
% Households w/No Broadband
% No Health Insurance
% of Civilians 18+ that are Veterans
% Paying >30% of Income for Housing
% Speaks English not "very well"
% Unemployed Aged 16+ in Civilian Labor Force
Value Range (Higher # is Darker Orange)
1.6%
24.1%
Lewiston
Kennewick
Walla Walla
Orangeville
OREGON
Boise
Mountain Home
Jordan Valley
24.1%
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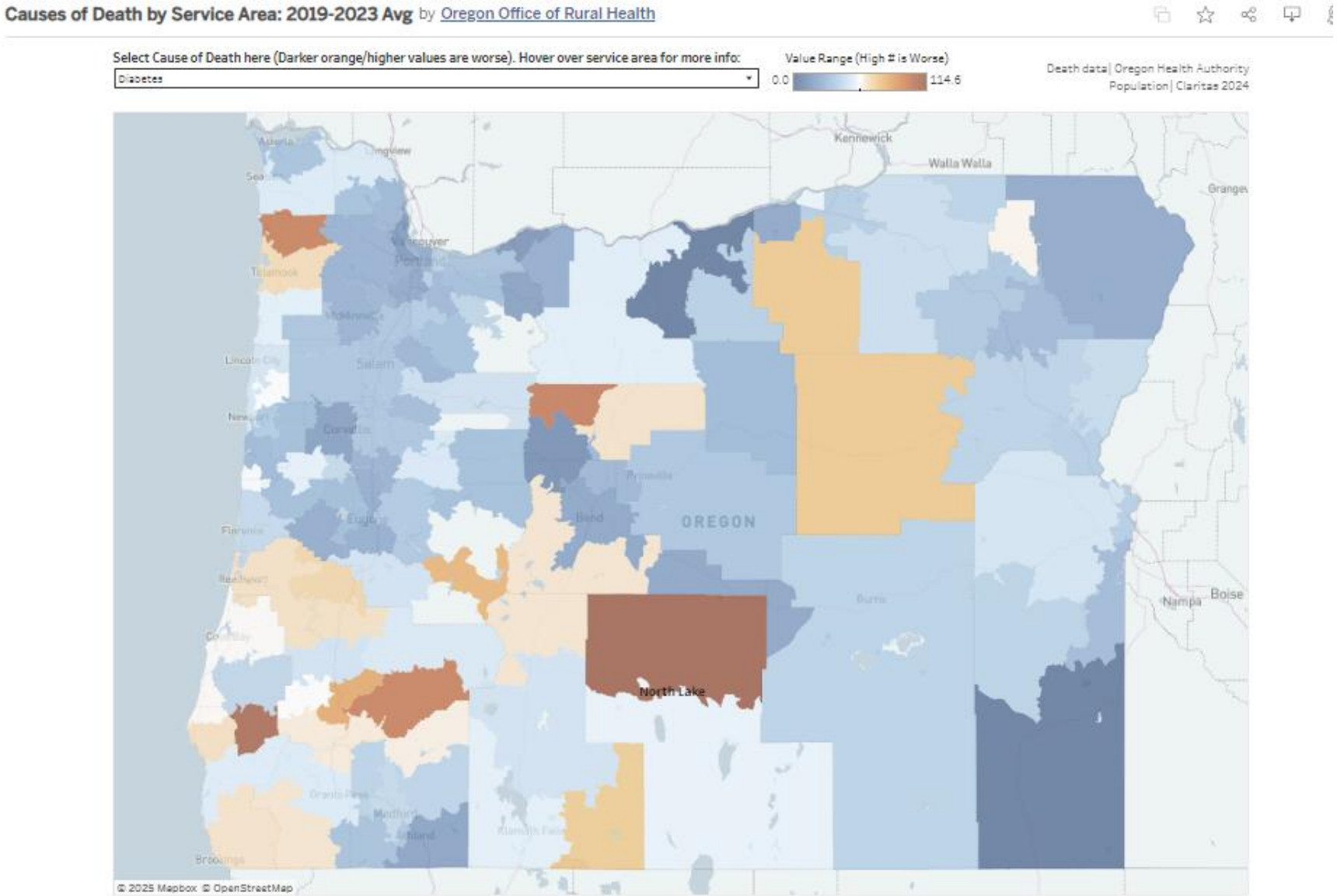


https://public.tableau.com/app/profile/oorh/viz/CausesofDeathbyServiceArea/Dashboard?publish=yes

Implementing Chronic Care Management In-house

Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Frequently Asked Questions

December 2019

Topics:

I. Care Management Services – General

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

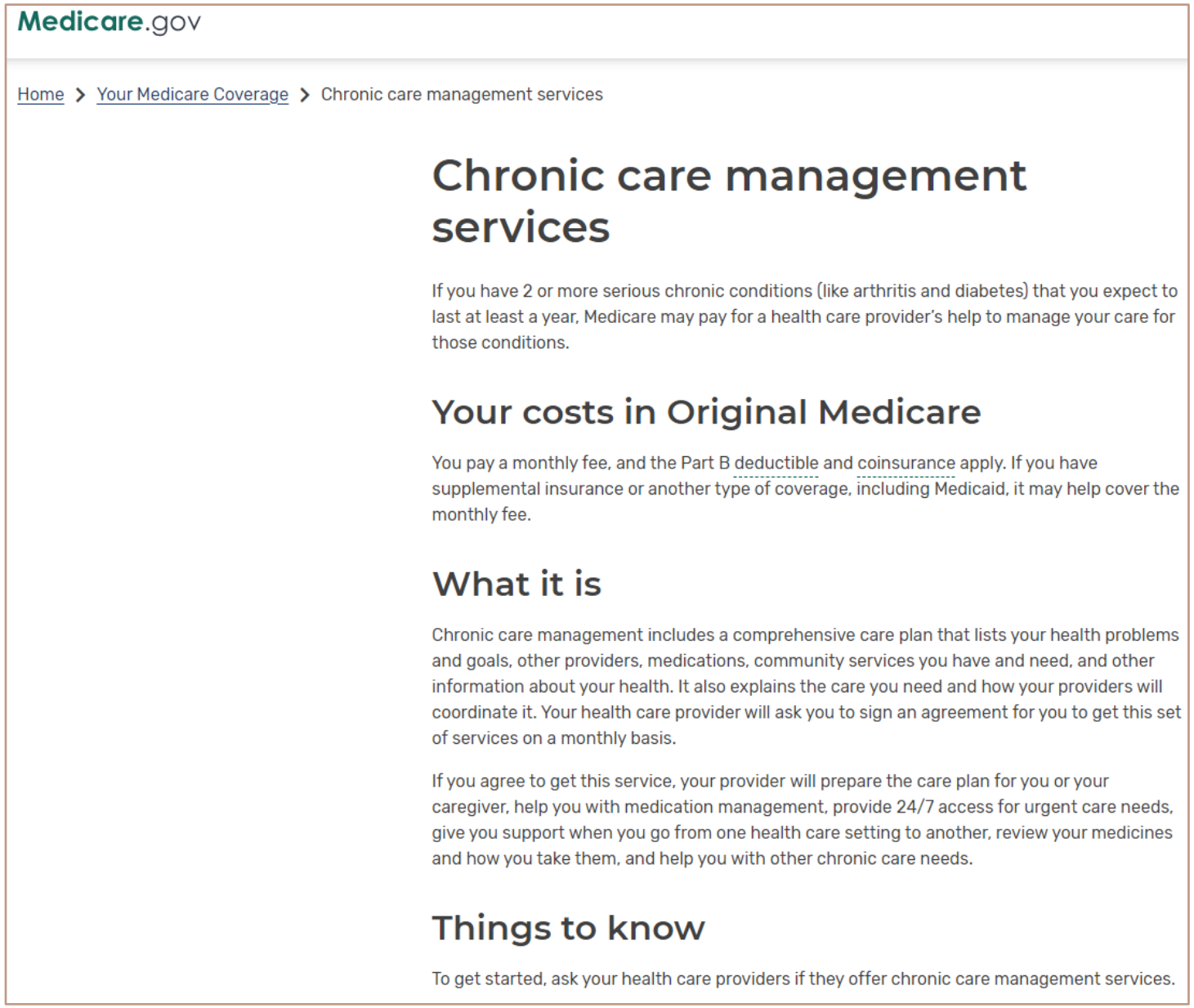
Addendum I
CCM, General BHI, and Psychiatric CoCM Requirements and Payment For RHCs and FQHCs

Requirements	CCM	General BHI	Psychiatric CoCM
Initiating Visit	An E/M, AWV, or IPPE visit occurring no more than one-year prior to commencing care coordination services.	Same	Same
	Furnished by a primary care physician, NP, PA, or CNM.	Same	Same
	Separately billable RHC/FQHC visit.	Same	Same
Beneficiary Consent	Obtained during or after initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff.	Same	Same
	Written or verbal, documented in the medical record.	Same	Same
	Includes information: • On the availability of care coordination services and applicable cost-sharing; • That only one practitioner can furnish and be paid for care coordination services during a calendar month; • That the patient has right to stop care coordination services at any time (effective at the end of the calendar month); and • That the patient has given permission to consult with relevant specialists.	Same	Same
Billing Requirements	At least 20 minutes of care coordination services per calendar month that is: • Furnished under the direction of the RHC or FQHC primary care	Same	At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Requirements before Initiating Care Management Services

- **Initiating Visit**: E & M, AWV or IPPE visits no more than 12-months prior to starting care coordination services. An RHC provider must perform the initiating visit.
- **Beneficiary Consent**: Written or verbal; documented in medical record; patient educated on care coordination services; must give patient information about the cost-sharing for care management; that only one provider can furnish CCM; that the patient has the right to stop care; that the patient is giving permission for the RHC to consult and refer other providers.



Medicare.gov

Home > Your Medicare Coverage > Chronic care management services

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage your care for those conditions.

Your costs in Original Medicare

You pay a monthly fee, and the Part B deductible and coinsurance apply. If you have supplemental insurance or another type of coverage, including Medicaid, it may help cover the monthly fee.

What it is

Chronic care management includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other information about your health. It also explains the care you need and how your providers will coordinate it. Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis.

If you agree to get this service, your provider will prepare the care plan for you or your caregiver, help you with medication management, provide 24/7 access for urgent care needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs.

Things to know

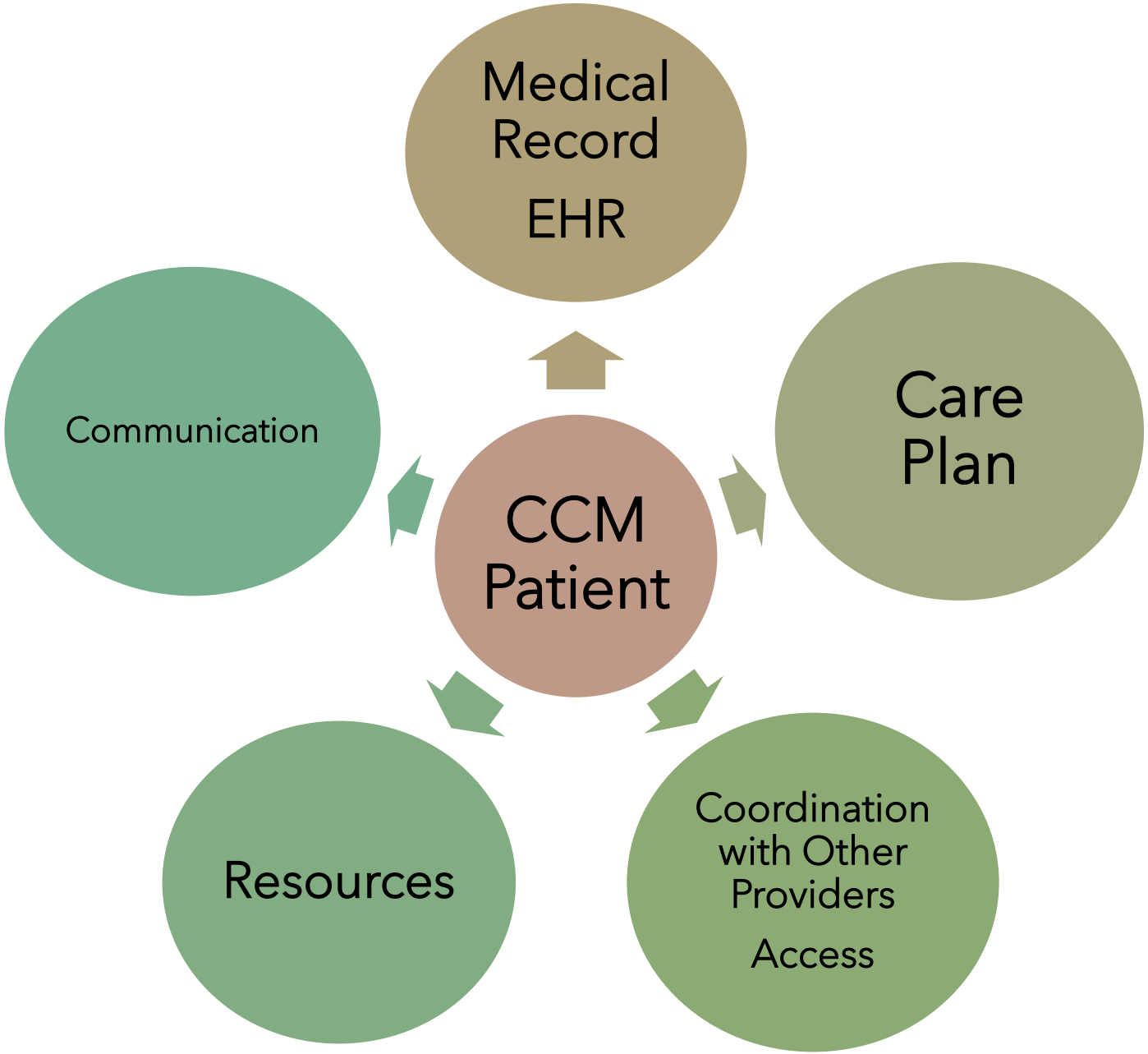
To get started, ask your health care providers if they offer chronic care management services.

CMS even gives you the language you need when educating the patient.

https://www.medicare.gov/coverage/chronic-care-management-services

Patient Eligibility

- Multiple (2 or more) chronic conditions expected to last more than 12 months or until the patient's demise.
- The conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Examples: Congestive Heart Failure, Diabetes, Heart Disease, Kidney Disease, Arthritis
- See requirements for new APCM Services



- Identification
- Assessment
- Care Plan
- Documentation
- Management
- Coordination of Care
- Care Transitions
- Communication
- Patient-Centered

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Chronic Care Management (CCM) Comprehensive Care Plan Template

The CCM Comprehensive Care Plan Template is designed to assist qualified healthcare professionals with proper documentation of the CCM services provided to their Medicare patients. Ensure that your electronic health record (EHR) system includes the following data elements listed in this document. Make the electronic version of this care plan available within and outside the billing practice to individuals involved in the patient's care. Provide patients and/or caregivers with a copy of the care plan.

Care Plan Initiation Date: _____ or Date of Revision: _____

Patient Information	
Name	
Date of birth	
Primary care physician	

Complete Problem List (You can elaborate on page 3.)	
Chronic health conditions	
Surgeries	
Tests/Procedures	

Complete Problem List (You can elaborate on page 3.)	
Chronic health conditions	
Surgeries	
Tests/Procedures	

Current Medications (List scheduled/PRN*/complementary or alternative medications.)		
Medication	**Dose**	**Frequency**

*PRN = as needed

Allergies

Preventive Care (Enter dates.)		
Vaccination	**Cancer Screenings**	**Annual Wellness Visit**
Flu:	Breast:	
Pneumonia:	Colon:	
Tetanus:		
COVID-19:		

Psychosocial Assessment	
Psychological and neuropsychological testing (i.e., assessment/patient health questionnaire 2 [PHQ-2])	
Current employment status	
Household composition	
Environmental evaluation	
Threats of violence/injury	

Functional Assessment	
Activities of daily living	
Caregiver assessment	

Chronic Condition #1—Goals and Interventions	
Chronic condition #1	
Prognosis	
Symptom management (Include any educational resources provided.)	
Measurable treatment goals	
Planned interventions	
Coordination of care	

Chronic Condition #2—Goals and Interventions	
Chronic condition #2	
Prognosis	
Symptom management (Include any educational resources provided.)	
Measurable treatment goals	
Planned interventions	
Coordination of care	

Community and/or social services ordered (Check the appropriate box.)

❑ Yes ❑ No

If yes, please list the services ordered:

_____

_____

Care team (Include roles and responsibilities.)	
Role	**Responsibilities**

Medication list reviewed: ❑ Yes ❑ No

Medication reconciliation last completed date: _____

Care plan reviewed and shared with patient: ❑ Yes ❑ No

Care plan reviewed and shared date: _____

Care plan reviewed and shared with patient: ❑ Yes ❑ No

Care plan reviewed and shared date: _____

Care Management Follow-up Activities	
Activity/task description	**Time spent (in minutes)**

https://hsag.com/globalassets/12sow/physician-practices/ccmcompcareplantemplate_508.pdf

Prior to On-boarding Patients

Create your infrastructure

Have a dedicated care management coordinator/manager; don't add something on to an already overloaded nurse.

Design Your Program

How is it going to work?
Who will do what?
What is the workflow?
How to document?

Build external connections & communications

Emergency dept
Case Management
Other Providers
Pharmacy
Social Services

In-house Organic Patient Onboarding

Start with your schedule

Identify patients who are already receiving care as the starting point; Who is coming in this week? Next week? Who has an AWV scheduled?

In-Person Consent & Enrollment

Not required but more effective and personable; can begin personalizing care plan

Care Management Begins

This facilitates more controlled growth of the program although growth may be slower at first.

Provide Care Management

Engage the Patient

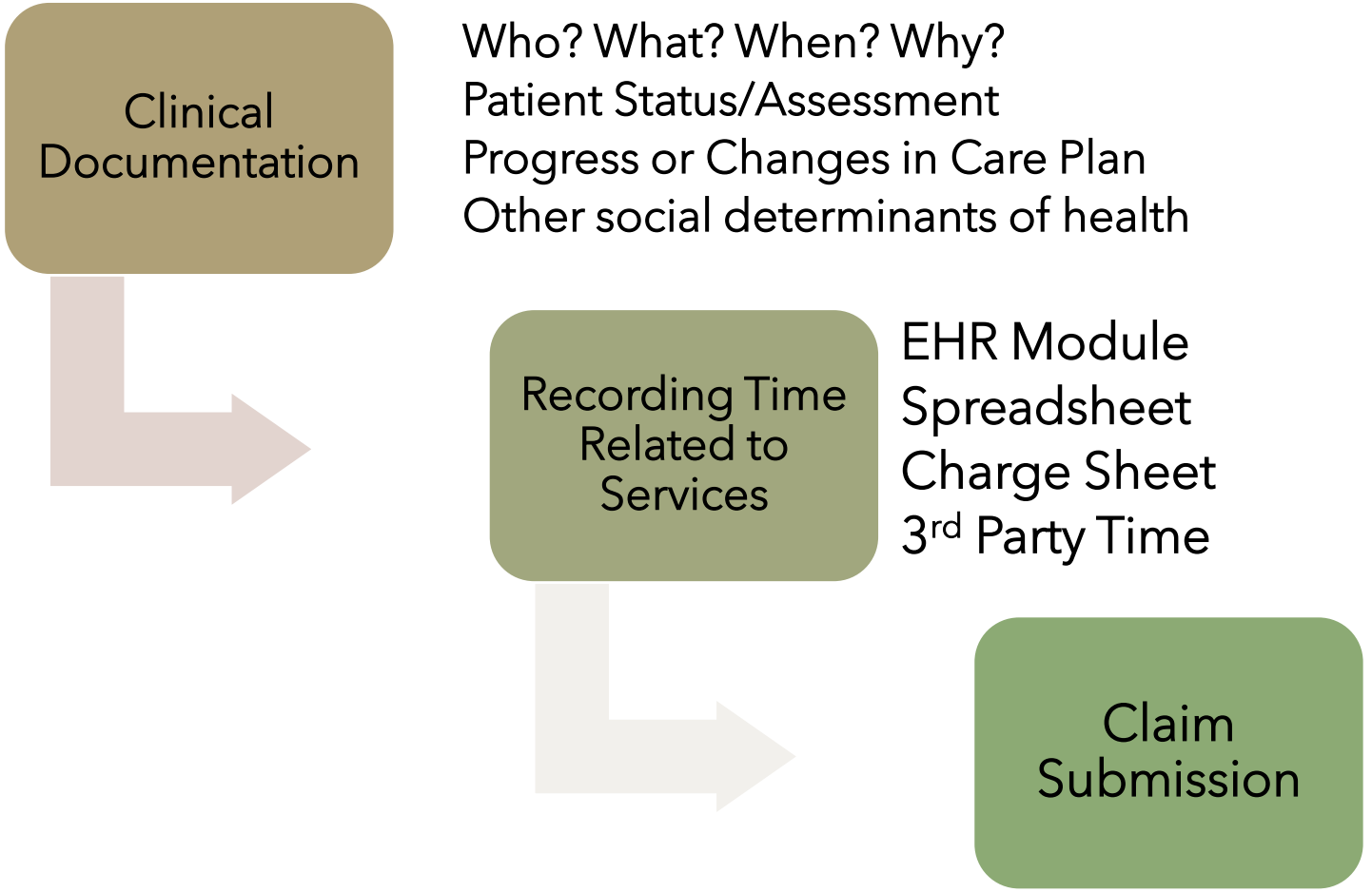
Don't just call and question the patient. Bring them into their own care plan so that the goals and outcomes can be obtained.

Feedback Loop with Provider and other caregivers

Don't run the program in a vacuum. Communication is key to success.

Update Care Plan as Needed

Documentation and Recordkeeping



Discussion on Care Management Questions/Comments?

Special thanks to Kristen Ogden (The Compliance Team); Aubrey Haynes (Pillow Clinic/NARHC) and Lesa Schlatman (Hometown Health) who assisted me in compiling some of this content.

Upcoming Noridian Webinar

Rural Health Center (RHC) Compliance Webinar - 06/11/2025

The Noridian Provider Outreach and Education (POE) staff is hosting the Rural Health Center (RHC) Compliance webinar on 06/11/2025 at 1:00 PM PT.

This event includes:

- New in 2025
- RHC Certification
- The RHC Visit
- RHC Services
- Non-RHC Services
- Resources

When registering, you will be asked "What question do you hope to have answered by attending this event?" By talking with your peers and billing office staff members prior to registering, you can help ensure Noridian delivers tailored outreach to meet your needs.

To sign up for this webinar or other events of interest, visit the Noridian Schedule of Events.

Last Updated Apr 30 , 2025

https://med.noridianmedicare.com/web/jea/article-detail/-/view/10521/rural-health-center-rhc-compliance-webinar-06112025

https://register.gotowebinar.com/register/6675730374979924314

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