Preparing for 2025: How New Regulations Impact Credentialing

New regulations from the **Centers for Medicare & Medicaid Services (CMS)** continue to shape medical billing practices, with notable implications for healthcare providers' credentialing. Credentialing is a foundational component of the medical billing process, ensuring that providers meet the necessary standards to participate in Medicare and Medicaid programs and are eligible for reimbursement.

With recent regulatory shifts impacting telehealth, primary care, cardiovascular care, and other service areas, healthcare providers must stay updated on evolving credentialing requirements to remain compliant and avoid potential billing issues. This analysis examines how these regulatory changes affect credentialing.

Impact of 2025 Regulations on Credentialing

1. Telehealth Policies

Telehealth has become an essential mode of healthcare delivery, and new CMS policies for 2025 reflect continued flexibility while tightening standards for **telehealth credentialing**.

Effective January 1, 2025, Medicare telehealth services can be provided via audio-only technology when patients are unable or unwilling to use video technology. Credentialing for telehealth providers now must ensure they are equipped with necessary capabilities, including interactive telecommunications technology. Providers must document technical abilities for telehealth, especially if serving Medicare beneficiaries who require real-time, audio-only services.

Another change extends permission through 2025 for practitioners to list practice addresses on telehealth claims instead of their home addresses when providing services from home. Credentialing departments must verify providers' compliance with these location requirements. This shift requires documentation that telehealth practitioners are enrolled at a valid practice location and capable of fulfilling these Medicare standards.

Virtual supervision, another aspect of the CMS telehealth rule, affects credentialing for supervisory roles, allowing supervising physicians to be present virtually via real-time video and audio in specific situations. Credentialing departments must ensure that supervising practitioners meet the virtual presence criteria and document the approved settings for such supervision, particularly for outpatient services requiring oversight.

2. Advanced Primary Care Management Services (APCM)

The CMS's establishment of new Advanced Primary Care Management (APCM) codes (G0556, G0557, and G0558) to support primary care transformation also has credentialing implications. These codes are structured around the complexity of patients' conditions and allow providers to bill for comprehensive primary care without time-based requirements, simplifying administrative tasks. However, providers utilizing these APCM codes must meet specific qualifications and service standards, including 24/7 access and continuity of care, comprehensive care planning, and care coordination.

Credentialing must verify that providers meet these new requirements and possess the competencies to deliver such comprehensive care. This involves ensuring that providers have training in managing chronic conditions, coordinating care transitions, and maintaining care continuity. Credentialing for APCM is further complicated by the integration of the Merit-Based Incentive Payment System (MIPS), wherein providers must meet primary care quality measures to bill for APCM services. MIPS eligibility criteria now factor into credentialing for providers delivering these advanced services, requiring verification of past performance metrics and enrollment in an advanced care model to bill these codes effectively.

3. Cardiovascular Risk Assessment and Management Services

In response to the success of the Million Hearts® Model, CMS finalized coding for cardiovascular risk assessment and management, which adds another layer to credentialing. The assessment codes are designed for patients at risk of cardiovascular disease (CVD) but without a formal diagnosis, necessitating standardized risk assessments that consider demographic data, modifiable risk factors, and laboratory data. Credentialing teams must now confirm that healthcare providers are trained in CVD risk assessment and management and that they have the clinical competencies to conduct evidence-based evaluations.

Providers must also follow protocols for risk management services, which include strategies for aspirin use, blood pressure management, cholesterol management, and smoking cessation. Credentialing will need to ensure providers are credentialed in using the ASCVD risk assessment tool and proficient in the management of intermediate and high-risk patients. This policy emphasizes preventive care for CVD, and credentialing must align with the qualifications necessary to meet CMS's risk reduction standards.

4. Therapy Services

Regulatory changes also impact credentialing for physical, occupational, and speech therapy services. CMS's recent rule allows therapists to bypass physician signatures on treatment plans when certain conditions are met, such as having a documented physician order on file.

This change requires credentialing departments to confirm therapists' documentation skills and ensure adherence to policy regarding timely transmission of treatment plans to supervising physicians.
Therapists' credentialing must now account for their ability to manage treatment plans independently under certain conditions, meaning credentialing processes should include training and assessment of documentation capabilities, communication with physicians, and adherence to updated regulatory guidelines. Additionally, credentialing departments may need to clarify roles when new patients initiate therapy and ensure compliance with Medicare's initial certification and documentation standards.

5. New Dental and Oral Health Service Policies

CMS's decision to cover dental and oral health services tied to specific medical conditions, such as end-stage renal disease, further influences credentialing. Effective July 1, 2025, Medicare will require the KX modifier on claims for covered dental services. This update means dental providers billing Medicare must credential to ensure eligibility and training to meet CMS's specific coding and modifier requirements. Credentialing teams must now evaluate dental providers' familiarity with the 837D dental claims format, knowledge of diagnosis coding, and correct use of the KX modifier, especially in cases of medically necessary services linked to covered conditions.
Credentialing for these dental providers must include verification of expertise in treating medical conditions related to dialysis, as well as understanding of the link between oral health and chronic disease management. This shift emphasizes that providers delivering multidisciplinary care need credentials supporting complex patient care models, aligning oral and general healthcare to Medicare's standards.

Looking for Expert Advice?

Outsourcing to **24/7 Medical Billing Services (MBS)** can be invaluable for healthcare providers dealing with these complex regulatory updates. With a deep understanding of CMS guidelines, 24/7 MBS provides tailored support to ensure providers remain compliant with new credentialing requirements, especially those impacting telehealth, advanced primary care, cardiovascular services, and more. Their team offers expert guidance on implementing updated protocols, handling compliance documentation, and managing billing nuances like the correct application of modifiers for drugs and services.