

# Publications

July 30, 2025 • Updates

## Virtual Oversight, Real Impacts: “Incident-To” and Beyond in CMS’s CY 2026 PFS Proposed Rule

### Key Takeaways

- CMS proposes to significantly expand the use of virtual direct supervision for incident-to services, removing prior limitations based on Professional Component (PC)/Technical Component (TC) indicators and Current Procedural Terminology (CPT) codes.
- Without these proposed changes, most services requiring direct supervision would revert to requiring the supervising practitioner’s physical presence after the PHE-era flexibility ends on December 31, 2025, and only a narrow subset of incident-to services will be eligible for virtual supervision starting on January 1, 2026.

In the recently released Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) signal a significant shift toward modernizing Medicare’s supervision requirements for “incident to” services. Specifically, CMS proposes to make permanent the ability to meet the direct supervision requirement through real-time, two-way audiovisual technology (excluding audio-only), a flexibility broadly introduced during the COVID-19 Public Health Emergency (PHE). This move, if finalized, will have sweeping implications for clinical operations, staffing models and compliance protocols in Medicare participating practices and clinics.

### What is Direct Supervision?

Under CMS’s established framework, Part B services may be subject to one of three supervision levels: general supervision, direct supervision or personal supervision. Direct supervision has historically required that the physician (or other supervising practitioner) be present in the office suite and “immediately available” to furnish assistance and direction throughout the performance of the service. CMS has historically considered “immediate availability” to mean in-person, physical, not virtual, availability. Direct supervision is required for various types of services, including most incident-to services, many diagnostic tests, pulmonary rehabilitation services, cardiac and intensive cardiac rehabilitation services and certain hospital outpatient services.

One of the more common billing scenarios requiring direct supervision is when services

### Related People

- Sean A. Timmons
- Kathleen Snow Sutton
- Colleen E. Guinn

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are provided “incident to” a physician’s (or non-physician practitioner’s (NPP’s)) professional services in a physician office or clinic. These services, which are often delivered by nurses, medical assistants or other auxiliary personnel, must be provided as part of a plan of care established by the billing practitioner. A critical requirement for billing under the incident to provision is direct supervision, which as noted above requires the supervising practitioner to be immediately available to intervene.

### **PHE Era Flexibilities (Temporary, Through December 31, 2025)**

As a result of the PHE, CMS temporarily amended the definition of “direct supervision” to state that the necessary presence of the physician (or other practitioner) for direct supervision includes virtual presence through real-time, interactive audio-video technology. Instead of requiring the supervising physician’s or NPP’s physical presence, the temporary amendment permitted a supervising physician or NPP to be considered “immediately available” through virtual presence for diagnostic tests, pulmonary rehabilitation services, cardiac and intensive cardiac rehabilitation services, certain hospital outpatient services and importantly, incident-to services. This policy has been extended multiple times and is currently set to expire on December 31, 2025.

### **CY 2025 Final Rule (Effective January 1, 2026)**

As the end of the PHE neared, CMS recognized that an immediate reversion to the pre-PHE definition of direct supervision, which required physical presence, could create significant disruptions in care delivery, particularly for incident-to services. Stakeholder feedback highlighted how virtual direct supervision had enabled more flexible and efficient use of clinical staff, expanded access to care, and supported continuity of treatment during staffing shortages.

In response, in the CY 2025 PFS Final Rule, CMS finalized a permanent, though narrower, policy to preserve virtual supervision flexibility for certain incident-to services. Specifically, beginning on January 1, 2026, virtual direct supervision may be provided for incident-to services where (1) the applicable service is furnished by auxiliary personnel who are employed by the physician (or other practitioner) and working under the physician’s (or other practitioner’s) direct supervision; and (2) the applicable service either (a) has a Healthcare Common Procedure Coding System (HCPCS) code with a PC/TC indicator of ‘5’ (i.e., generally services where there is no separate payment under the PFS); or (b) is described by CPT code 99211 (office or outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care practitioner).

Importantly, the permanent policy that goes into effect on January 1, 2026, only applies to the aforementioned subset of incident-to services and does not apply to other services (including other incident-to services that do not meet the requirements of the rule) required to be furnished under direct supervision. Absent additional policy changes, after December 31, 2025, such services will require in-person, physical presence for purposes of direct supervision.

### **Proposed CY 2026 Virtual Direct Supervision Expansion**

In the CY 2026 PFS proposed rule, CMS is now proposing to expand virtual direct supervision to cover nearly all “incident-to” services, as well as cardiac, pulmonary and intensive cardiac rehabilitation services.

This is a considerable expansion in policy, particularly for incident-to services. This proposal goes beyond the limitations of the CY 2025 Final Rule (at 42 CFR § 410.26(a)(2)) by removing the need for services to be tied to a PC/TC indicator of 5 or CPT code 99211.

Instead, virtual direct supervision would be permissible for all services billable as “incident-to,” except for those assigned a global surgery indicator of 010 or 090 (i.e., procedures with 10-day or 90-day global periods – CMS justifies this exclusion on the basis of clinical complexity and the importance of in-person availability during perioperative periods). Additionally, CMS highlights that while this proposal would allow immediate availability through virtual means for a majority of incident-to services, it does not mean that it is appropriate to allow virtual presence for every service for every Medicare beneficiary in every clinical scenario. As always, the physician or NPP should use his or her complex professional judgment to determine the appropriate supervision.

## Implications for Providers

If finalized, this proposal could reshape how clinical supervision is operationalized in outpatient settings, particularly for:

- **Primary care and specialty practices:** Expanded flexibility in supervising advanced practice providers and clinical staff, including across locations or via hybrid/remote arrangements.
- **Compliance teams:** Need to update supervision protocols, telehealth technology standards and audit documentation practices to clearly demonstrate real-time audiovisual connectivity and supervisory availability.
- **Risk management:** While CMS hasn’t proposed specific documentation requirements, providers should proactively log supervisory modality and ensure coverage protocols are in place during patient care encounters.
- **State law alignment:** Importantly, state scope-of-practice and licensure rules still govern clinical delegation and supervision. Virtual supervision permissible under Medicare may still be constrained at the state level.

## CMS Seeking Comments

CMS’s proposed rule for CY 2026 reflects a continued shift toward modernizing Medicare’s approach to care delivery and clinical oversight. Providers and health systems that rely on incident-to billing, or have concerns about the proposal’s limitations, should consider submitting comments. The comment period closes on September 12, 2025, and stakeholder input plays a critical role in shaping final policy.

If your organization is interested in submitting feedback, our firm has experience advising providers and health care organizations on effective regulatory commenting strategies.