

WISeR Model Frequently Asked Questions

[WISeR Model Frequently Asked Questions | CMS](#)

1. Does WISeR change Medicare coverage policy?

No. Instead, WISeR supports the accuracy and efficiency of CMS's review for compliance with existing coverage policy in statutes, regulations, National Coverage Determinations, and Local Coverage Determinations. All providers and suppliers are expected to adhere to these policies when providing services to Medicare beneficiaries.

Health care coverage for people with Medicare will not change, and they retain the freedom to seek care from their Original Medicare provider or supplier of choice. Payment to providers and suppliers for covered services will not change under the model.

2. Does WISeR apply to all items and services in Original Medicare?

No. WISeR targets a narrow set of items and services that have been a source of fraud, waste, abuse, and inappropriate utilization, and which can present a very real threat of patient harm. Examples include skin substitutes, knee arthroscopy for knee osteoarthritis and electrical nerve stimulation. The list was derived through a careful review of existing National and Local Coverage determinations, clinical and academic literature, and reports from the U.S. Department of Health and Human Services (HHS) Office of Inspector General.

3. How does WISeR protect patients?

A primary goal of WISeR is to help patients avoid unnecessary, inappropriate procedures that may cause potential harm such as pain, bleeding, infection, anxiety, or other adverse effects and instead promote high-value services aligned with evidence-based care guidelines.

WISeR applies to a narrow set of items and services that: 1) may pose concerns related to patient safety if delivered inappropriately; 2) have existing publicly available coverage criteria; and 3) may involve prior reports of fraud, waste and abuse.

The model excludes inpatient-only services, emergency services, and services that would pose a substantial risk to patients if delayed. However, a provider or supplier may request an expedited review, if needed.

Monitoring metrics for WISeR participants will promote patient safety and appropriate care, including holding model participants accountable for their

accuracy on determinations and ensuring they are not unnecessarily increasing inappropriate denials.

Bottom line: Most health care providers prioritize patient health and safety over profit. But, an unfortunate truth, as evident by past law enforcement cases, is that some health care providers abuse Medicare by providing expensive items or services, like skin substitutes or implantation of electrical nerve stimulators, in situations where the patients may not benefit and where they do not meet Medicare coverage criteria. WISeR will proactively curtail these practices.

4. How will WISeR streamline current coverage review for both people with Medicare and providers?

WISeR is intended to improve speed, accuracy and consistency of review for adherence to existing coverage policy by leveraging technology to determine whether a claim is payable before services are rendered for providers who opt for prior authorization, or before payment is made for providers who do not opt for prior authorization.

The aim is to drive towards 'auto-approvals' of requests, wherever possible. Most response times will be within 72 hours, and, in many cases, the response will be much faster.

Benefit to Patients: Patients receive a fast, accurate determination of whether certain services are reasonable and necessary, promoting safety and the most appropriate, effective care for their conditions.

Benefit for Health Care Providers and Suppliers: Health care providers and suppliers who opt for prior authorization will know in advance that they will be paid for the services they are delivering so long as all of the applicable Medicare coverage and clinical documentation are met, and the claim was billed and submitted correctly. CMS, in conjunction with model participants, will offer provider education for transparency and predictability. Providers and suppliers with a demonstrated record of compliance may receive a limited exemption or "gold card" from the WISeR full review process in the future. This will help ensure the model focuses on providers and suppliers at higher risk of delivering unnecessary and potentially unsafe care.

5. How will WISeR ensure Medicare savings?

Model participants will only be compensated if they reduce wasteful, inappropriate care, receiving a percentage of the savings associated with their reviews. At the same time, CMS will perform rigorous oversight, and participants will be financially penalized for inappropriate denials.

6. How will WISeR safeguard against inappropriate non-affirmations (denials)?

Non-affirmations will require the review of a human clinician and cannot be performed solely by technology. Moreover, the payment methodology disincentivizes inappropriate non-affirmations in several ways:

- CMS will audit participants to ensure that determinations are consistent with Medicare coverage criteria. Audit results contribute to participants' quality scores, resulting in negative payment adjustments for inaccurate determinations. Further, participants who have a high rate of inaccuracy may be terminated from the model.
- Model participants are responsible for the cost of processing prior authorization requests, including unlimited resubmissions of a non-affirmed request.
- Participants will only be paid once per beneficiary, regardless of the number of resubmissions, which incentivizes an accurate determination at the time of the first request.
- Providers, suppliers, and beneficiaries will retain their rights to appeal any denied claims and participants will not be paid (or will have payments recouped) for any non-affirmations followed by a successful claims appeal.

7. How will WISeR protect beneficiary data?

The Wasteful and Inappropriate Service Reduction (WISeR) Model reflects the CMS Innovation Center's commitment to protect federal taxpayers and the Department of Health and Human Services (HHS) and CMS pledge to protect people with Original Medicare by crushing fraud, waste and abuse. In addition to saving taxpayer dollars, the model aims to reduce inappropriate, unnecessary and invasive procedures (in line with existing Original Medicare prior authorization policy) that can significantly harm patients while also improving upon the existing prior authorization process to streamline efficiency and improve accuracy by leveraging enhanced technologies.

Moreover, CMS has policies and procedures that limit model participants' access and use of Personally Identifiable Information (PII) and Protected Health Information (PHI), in accordance with the Privacy Act of 1974, HIPAA regulations, and other applicable federal laws.

8. How else will participating companies be held accountable?

While enhanced technology aims to expedite the prior authorization process, any recommendations that coverage should not be provisionally affirmed will be

made by an appropriately licensed human clinician, not a machine. If the item or service is provided, providers, suppliers and people with Medicare will have the ability to appeal claims decisions as usual. Participating companies will be held to requirements such as:

- demonstrated ability to interpret and apply clinical coverage criteria derived from National Coverage Determinations or Local Coverage Determinations;
- experience using enhanced technology, including with other payers or health plans, to streamline approval processes;
- ensuring appropriate clinical expertise is incorporated into the pre-approval process and to conduct medical reviews; and
- capability to offer back up options to advanced technologies, including phone, fax, electronic portals and regular mail.

9. How does WISeR align with the HHS Secretary Robert F. Kennedy, Jr's and CMS Administrator Dr. Mehmet Oz's pledge to fix the prior authorization system.

Prior authorization can ensure that beneficiaries receive timely access to services that are medically necessary, clinically appropriate, and evidence-based when applied in a targeted manner. The Kennedy [pledge](#) is about the right balance for review: enough to protect patients but not so much that it interferes with their timely access to medically necessary care:

- WISeR models best practices in Original Medicare for how to conduct prior authorization. It zeroes in on those services that are vulnerable to waste and abuse—and have the possibility of being harmful to patients if misused—because of inadequate implementation of existing statutes, regulations, National Coverage Determinations, and Local Coverage Determinations.
- Medicare Advantage reforms aim to reduce prior authorization where it has become unnecessary and burdensome to patients and providers.

While WISeR applies to Original Medicare and the pledge applies to Medicare Advantage, the model aligns with the pledge's goals to:

- Enhance transparency and communication around authorization decisions and appeals.
- Expand real-time responses to minimize delays in care with real-time approvals for most requests by 2027.
 - Ensure medical professionals review all clinical denials.

10. Why did CMS develop WISeR?

The WISeR model reflects the CMS Innovation Center's commitment to protect federal taxpayers and the Department of Health and Human Services (HHS) and CMS pledge to protect people with Original Medicare by crushing fraud, waste and abuse. In addition to saving taxpayer dollars, the model aims to reduce inappropriate, unnecessary and invasive procedures (in line with existing Original Medicare prior authorization policy) that can significantly harm patients while also improving upon the existing prior authorization process to streamline efficiency and improve accuracy by leveraging enhanced technologies.

11. How does WISeR fit into the Innovation Center Strategy?

WISeR addresses all three pillars of the Innovation Center's strategic direction to:

- **Promote evidence-based prevention** by introducing clinical review with enhanced technology to ensure patients are receiving the most appropriate and effective care, which can include focusing more on prevention and less on costly, potentially invasive and inappropriate care.
- **Empower people to achieve their health goals** by setting the stage for beneficiaries partnering with their clinicians on the most effective care plans and, where possible, providing them with more information about their care.
- **Drive choice and competition for people** by applying new tools in Original Medicare; and by incentivizing participating companies to help deliver fast, accurate, transparent prior authorization decisions and holding those companies accountable for their performance.

Moving forward, the Innovation Center will prioritize the role of technology in improving quality and reducing cost.

12. How will providers or suppliers in model test regions submit a prior authorization request?

Providers or suppliers in a designated region for the model who choose to submit a request for covered services will send all relevant information to support Medicare coverage of the selected services either directly to the company participating in WISeR for that region or to their Medicare Administrative Contractor (MAC), which will then route it to the model participant.

The model participant will use enhanced technology to support coverage determinations and seek medical review by clinicians with relevant expertise, as needed. Model participants will notify the provider or supplier of the decision.

Providers and suppliers, however, are not required to submit a prior authorization request for a selected service. Should they choose not to, the claim for that service would be subject to post-service/pre-payment medical review.

13. How can a provider, supplier or beneficiary appeal a decision?

For a “non-affirmed” prior authorization request — meaning that a future service was found not to meet Medicare coverage, coding or payment requirements — the provider/supplier has unlimited opportunities to resubmit a request. A non-affirmed decision does not prevent the provider/supplier from delivering the service and submitting a claim. Submission of such a claim and denial by the MAC will constitute an initial payment determination, which would be subject to the existing administrative appeals processes available to providers, suppliers and people with Medicare.