Wasteful and Inappropriate Service Reduction (WISeR) Model Office Hour

Center for Medicare and Medicaid Innovation

July 17, 2025

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Office Hour Format

In today's office hour, we will answer:

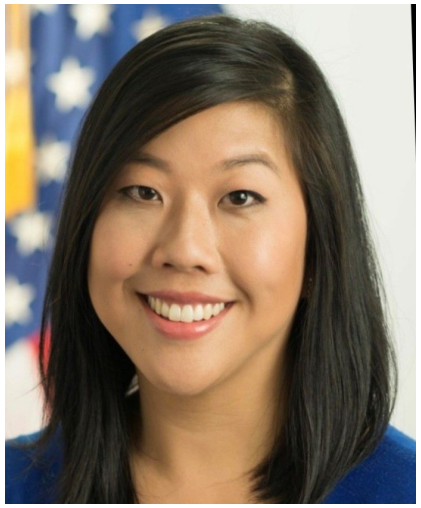
- **Common questions** submitted to our help desk and via **registration forms**
- **Live questions from participants** on the call

Please type your questions in the **Q&A box**.

If we do not get to your question, we welcome you to email the WISeR team at WISeR@cms.hhs.gov. We will aim to answer any unaddressed questions via emails and upcoming FAQs.

On Today's Call

Claire Kihn
WISeR Team Lead,
CMS Innovation Center



Alexandra Chong
Deputy Division Director,
CMS Innovation Center

Kate Blackwell
Division Director,
CMS Innovation Center

CMS Remarks

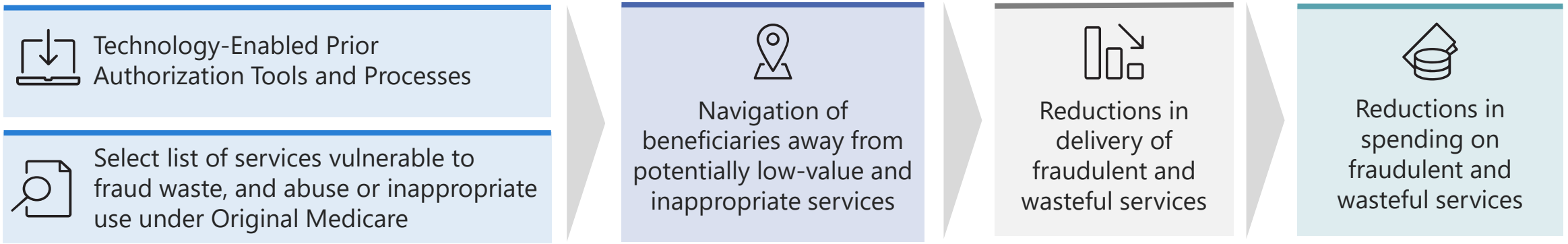
Model Overview

Model Overview

PROBLEM: Wasteful medical care spending accounts for an estimated **25% of total healthcare spending** with a substantial portion being attributable to fraud, waste (including low-value services), and abuse (FWA).

- Original Medicare spent between **$1.9 to $5.8 billion on low value services** in 2022.

SOLUTION: Implement a 6-year model with **companies that apply emerging technologies to clinical and claims processing solutions** as model participants to provide improved and expedited prior authorization processes for selected services in specific geographic areas in Original Medicare. **Leverage enhanced technologies** to ensure timely and appropriate Medicare payment for select services, streamline prior authorization processes, and help patients avoid unnecessary or inappropriate care.



High-Level Model Parameters

- 6-year voluntary model (two 3-year agreement periods)
- Application of prior authorization to a select set of services that have been identified as potentially vulnerable to fraud, waste, and abuse, and/or inappropriate use
- Applies to all providers/suppliers in selected geographic areas serving Original Medicare beneficiaries
- Companies specializing in enhanced technologies to improve and expedite the prior authorization process as model participants
- Model participants receive a portion of averted costs that can be attributed to their reduction of wasteful or inappropriate care for each selected service under the model.
- Performance metrics focus on prior authorization processing times and provider/supplier experience with prior authorization. Beneficiary experience and clinical quality outcomes will also be monitored/evaluated.

Impacted Providers and Suppliers and Model Participants

Medicare Providers & Suppliers

- ✓ All providers and suppliers in the selected geographic areas who are delivering services to Original Medicare beneficiaries
- ✓ Have the option to submit prior authorization requests and receive prior authorization determination for the model's selected services via streamlined processes implemented by the model participant and/or the Medicare Administrative Contractor (MAC) operating in the provider's region
- ✓ No change in provider/supplier payments or provider's/supplier's appeal rights

Technology Companies

- ✓ Demonstrated success in managing the prior authorization processes with enhanced technology for other payers/health plans
- ✓ Demonstrated ability to interpret and apply clinical coverage criteria derived from NCDs and LCDs
- ✓ Ensuring appropriate clinical expertise is incorporated into pre-approval and medical review process protecting and facilitating beneficiary and provider/supplier appeals
- ✓ Compliance with all applicable federal and CMS data protection and security requirements, HIPAA regulations, and other applicable privacy and security laws and CMS policies
- ✓ Capability to offer back-up options to advanced technologies, including phone, fax, electronic portals and regular mail

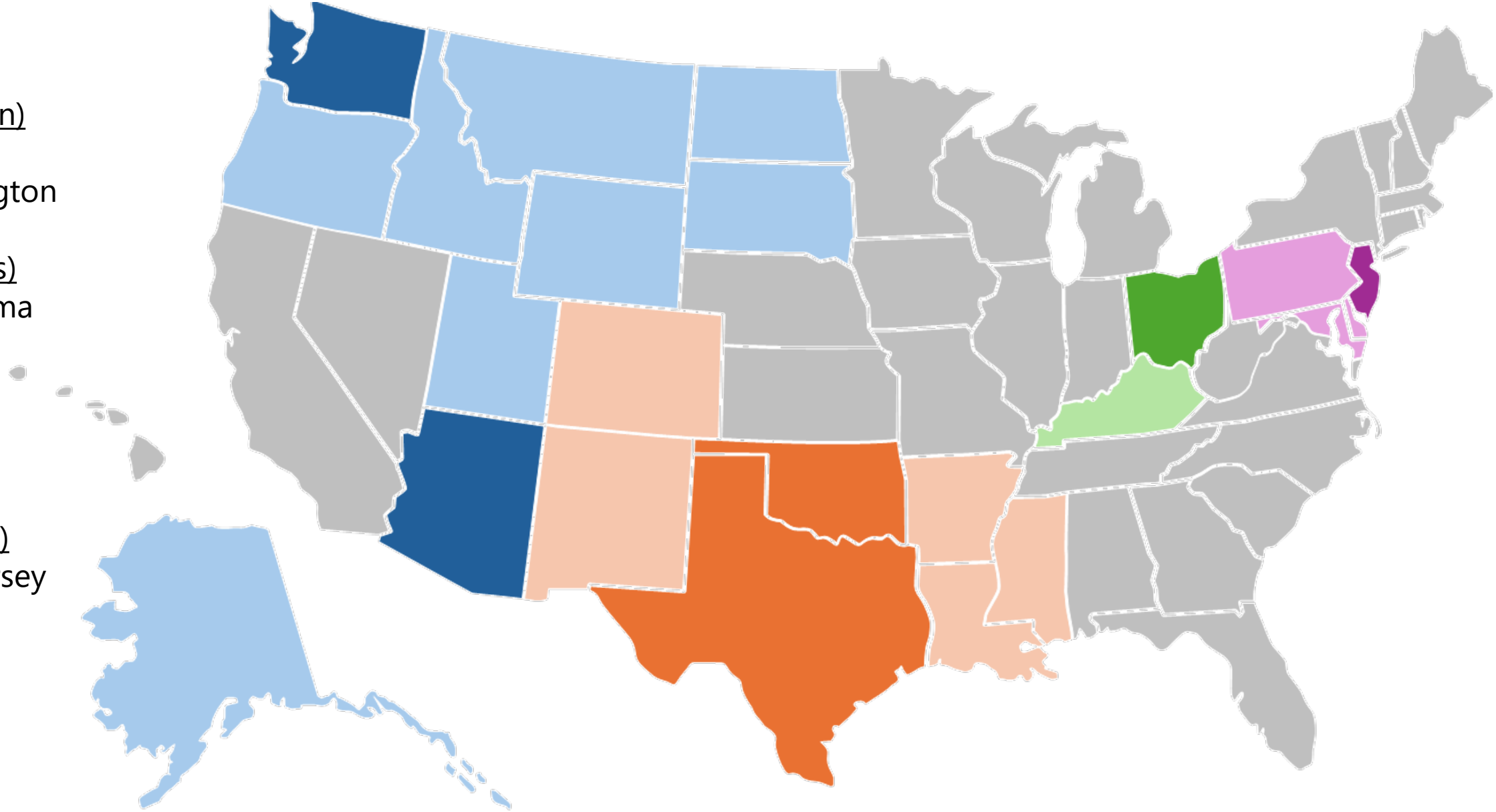
Selected MAC Jurisdictions and States

JF (Noridian)
- Arizona
- Washington

JH (Novitas)
- Oklahoma
- Texas

J15 (CGS)
- Ohio

JL (Novitas)
- New Jersey



Initial Service Selection Criteria

Leveraging Existing Evidence and Experience

- Services that have existing publicly available coverage requirements specified in statute, regulation, NCD, or LCD
- Services already subject to prior authorization by other payers

Patient Safety

- Non-emergent services
- Excludes inpatient only services
- Excludes first line diagnostics and treatments for a medical condition
- Prioritize standalone/non-repetitive services

Opportunity

- Services known to be a source of fraud, waste, or abuse (FWA) or potentially vulnerable to FWA
- Excludes services currently subject to other prior authorization programs
- Sufficient volume of services for evaluability

Services Included: Performance Year 1 (2026)

Service Category	Associated NCD/LCDs
Stimulator Services • Electrical Nerve Stimulators • Sacral Nerve Stimulation for Urinary Incontinence • Phrenic Nerve Stimulator • Deep Brain Stimulation for Essential Tremor and Parkinson's Disease • Vagus Nerve Stimulation	NCD 160.7 NCD 230.18 NCD 160.19 NCD 160.24 NCD 160.18
Induced Lesions of Nerve Tracts	NCD 160.1
Epidural Steroid Injections for Pain Management	L39015, L39242, L36920
Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)	L34106, L38201, L35130
Cervical Fusion (Excluding codes already included in OPD)	L39741, L39762, L39793
Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee	NCD 150.9
Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	L38307, L38312, L38385
Incontinence Control Devices	NCD 230.10
Diagnosis and Treatment of Impotence	NCD 230.4
Percutaneous Image-Guided Lumbar Decompression for Spinal Stenosis	NCD 150.13
Skin and Tissue Substitutes • Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds • Wound Application of Cellular and/or Tissue Based Products (CTPs), Lower Extremities	L35041 L36690

*CPT codes associated with selected services will be forthcoming.

Other Key Model Design Elements

Payment Approach

- No change in provider/supplier payments for services selected for prior authorization under the model
- Model participants are compensated based on a share of averted expenditures rather than on a fixed fee or per-claim basis
- Model payments are calculated from requests that did not result in a paid claim

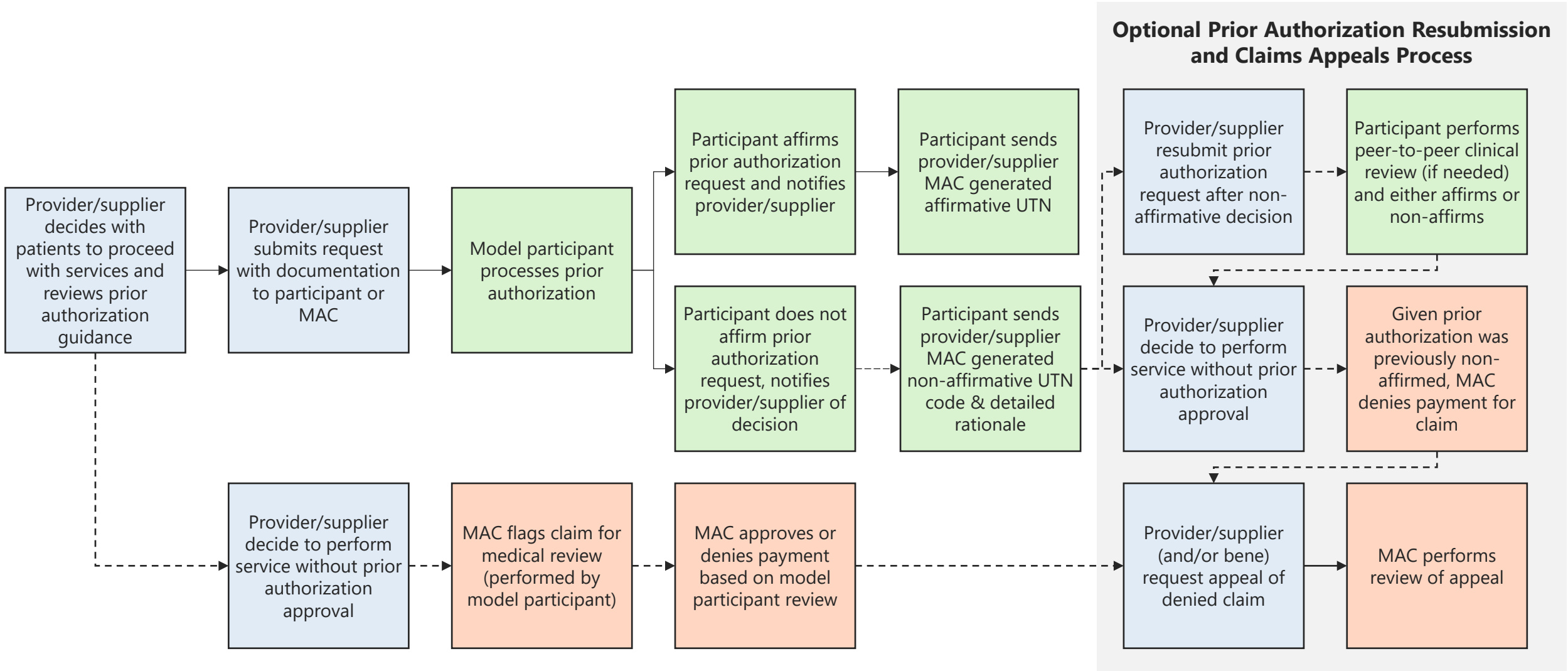
Quality and Performance Measurement

- Model participants monitored on metrics related to prior authorization process quality and payment adjustments based on efficiency/accuracy of their processes
- Provider/Supplier and Beneficiary Experience surveys
- Exploring inclusion of broad clinical outcomes that could be impacted by WISeR policies

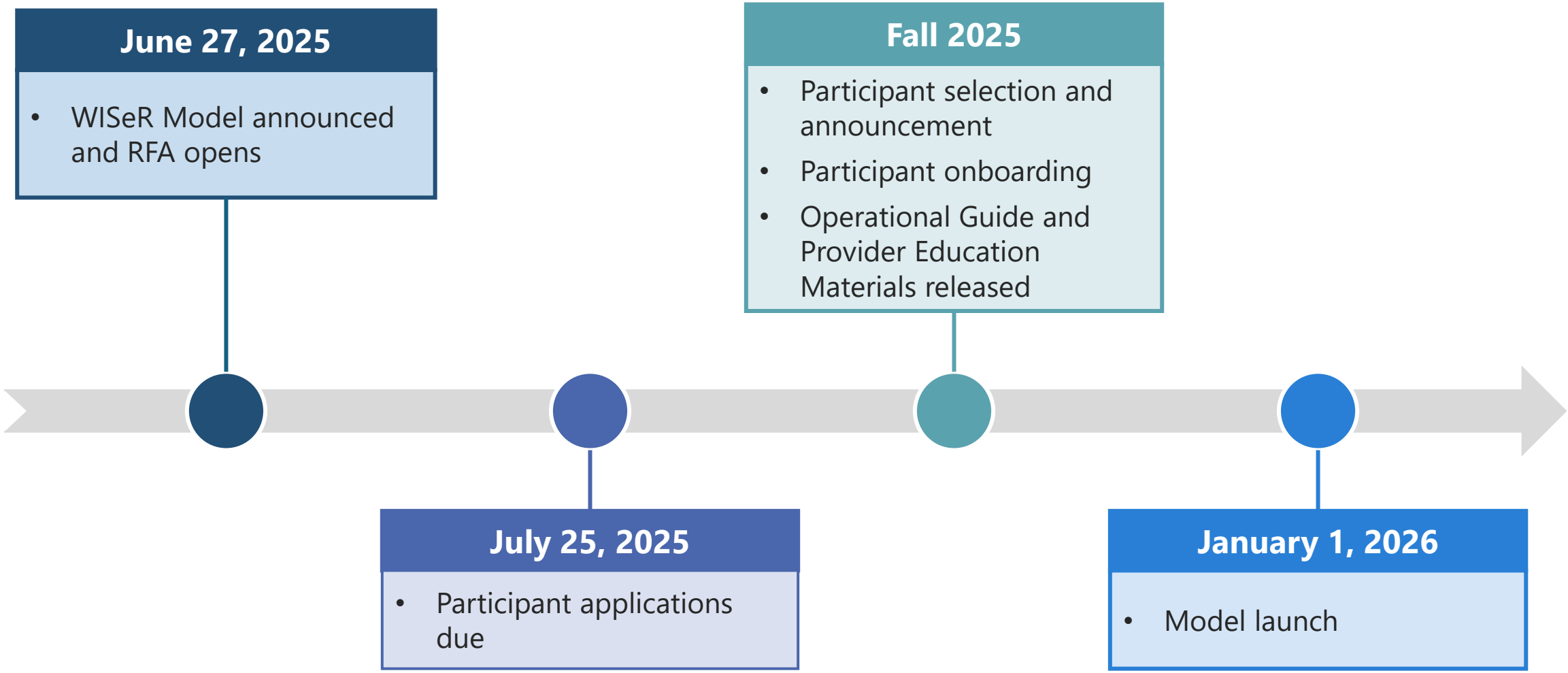
Evaluation

- As the model is limited to specific geographic areas, we anticipate comparison of key model metrics and outcomes over time against a matched comparison group to determine the model's impact.
- Key outcomes include:
  - Frequency of delivery and expenditures associated with selected services
  - Utilization of and expenditures on services that are substitutes for the selected services overall expenditures
  - Quality measures associated with the selected services

WISeR Prior Authorization Process Flow Chart



Timeline


June 27, 2025
• WISeR Model announced and RFA opens
July 25, 2025
• Participant applications due
Fall 2025
• Participant selection and announcement
• Participant onboarding
• Operational Guide and Provider Education Materials released
January 1, 2026
• Model launch

Additional Resources

Model Website

Request for Applications

Federal Register Notice

WISeR Help Desk: WISeR@cms.hhs.gov

Open Q&A

Please type your question in the **Q&A box.**

If we do not get to your question, we welcome you to email the WISeR team at WISeR@cms.hhs.gov. We will aim to answer unaddressed questions via emails and upcoming FAQs.

Closing

Thank You

We appreciate your time and interest!

Please share your feedback via the survey following this event.

Questions? Email WISeR@cms.hhs.gov