Centers for Medicare & Medicaid Services
Center for Medicare and
Medicaid Innovation

Wasteful and Inappropriate Service Reduction (WISeR) Model

Provider and Supplier Operational Guide

Version 5.0

Last Updated: March 12, 2026

Summary of Changes

Version 5.0 of the WISeR Provider and Supplier Operational Guide includes updated contact information for the WISeR Participants in Section 3.3. Additionally, modifications have been made to select codes and documentation requirements.

Version History

Version Number	Date of Update	Description of Change
1.0	October 10, 2025	N/A
2.0	November 6, 2025	Amends Appendix B, WISeR Associated Codes List Clarifies coding guidance for permanent implementation for Sacral Nerve Stimulation for Urinary Incontinence (Section 6.2.7) and Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (Tables A12 and C1)
3.0	December 23, 2025	Delays implementation of the Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis in WISeR (Section 6) Adds WISeR Participant Contact Information (Section 3.3) Removes Current Procedural Terminology (CPT) 22585 as a code requiring prior authorization and pre-payment review in Appendix A and relevant associated codes in Appendix B Amends Appendix B (WISeR Associated Codes List) as well as select Required Documentation (Section 6.2)

Version Number	Date of Update	Description of Change
4.0	February 12, 2026	Updates WISeR Participant and MAC contact information (Sections 3.3 and 3.4) Clarifies provisional partial affirmation and dismissal decision types (Section 4.1) Adds high-level information about the exemption program (Section 5) Reorders Appendices B and C: Appendix B now contains ICD-10 Indications for Relevant WISeR Items and Services, and Appendix C contains the WISeR Associated Codes List Removes ICD-10 code G47.33 as an indication for Vagus Nerve Stimulator requiring prior authorization and pre-payment review in Appendix B. Removes CPT codes C5271 through C5278 as skin substitute codes requiring prior authorization and pre-payment review in Appendix A and relevant associated codes in Appendix C
5.0	March 12, 2026	Updates WISeR Participant contact information (Sections 3.3) Clarifies indications for CPT 62323 that are out of scope for WISeR (Section 6.2 and Appendix A) Amends Appendix A (WISeR Select Items and Services) for Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea to include new HCPCS codes.

Table of Contents

List of Figures and Tables

Purpose

The Center for Medicare and Medicaid Innovation (CMMI) was established to test new payment and service delivery models that reduce Medicare and Medicaid costs while maintaining or improving the quality of care. The structure of Original Medicare often leads to unnecessary treatments and increases the risk of waste, fraud, and abuse. The Wasteful and Inappropriate Service Reduction (WISeR) Model tests the use of enhanced technologies, such as artificial intelligence and machine learning tools, to ensure that items and services furnished to beneficiaries in Original Medicare are in line with existing Medicare coverage criteria by working with organizations skilled in these technologies to improve the efficiency and accuracy of medical reviews. By focusing on services vulnerable to fraud and waste, the model seeks to decrease clinically inappropriate care and protect beneficiaries while ensuring continued access to appropriate services.

The purpose of the Provider and Supplier Operational Guide is to provide a practical overview of the prior authorization submission and determination process for Medicare-enrolled providers and suppliers that furnish and bill items and services included in the WISeR Model in the states in which the WISeR Model is being tested. The guide also addresses the pre-payment medical review process that will be triggered if claims for items and services included in the WISeR Model in states where the WISeR Model is operating are submitted without first obtaining prior authorization.

Select Statutory Medicare Requirements

For any service or item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare statutory and regulatory requirements

Social Security Act (Title XVIII) Standard References:[1] [2] [3]

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A), states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(1)(E), states that no Medicare payment shall be made in the case of research conducted pursuant to Section 1142 of the Act except for items and services that are reasonable and necessary to carry out that section.
- Title XVIII of Social Security Act, Section 1862(a)(10), states that no payment may be made under Part A or Part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection with cosmetic surgery, except as required for the prompt repair of accidental injury or improvement of the functioning of a malformed body member.

[1] Title XVIII of the Social Security Act, Section 1862, is available at Social Security Administration Website, Section 1862.
[2] Title XVIII of the Social Security Act, Section 1833, is available at Social Security Administration Website, Section 1833.
[3] Title XI of the Social Security Act, Section 1115A, is available at Social Security Administration Website, Section 1115A.

- Title XVIII of the Social Security Act, Section 1833(e), states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.
- Title XI of the Social Security Act, Section 1115A, authorizes the CMS Innovation Center to test innovative payment and service delivery models that aim to reduce program expenditures while preserving or enhancing the quality of care for individuals under Medicare, Medicaid, or the Children's Health Insurance Program.

Statutory Waiver Authority:

Section 1115A(d)(1) of the Act authorizes the Secretary to waive such requirements of Titles XI and XVIII and of Sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) of the Act as may be necessary solely for purposes of carrying out Section 1115A of the Act with respect to testing models described in Section 1115A(b) of the Act. For this model, consistent with this standard, such provisions of Sections 1834(a)(15) and 1869(h) of the Act will be waived that limit the Centers for Medicare & Medicaid Services' (CMS) ability to conduct prior authorization. Although these provisions are specific to durable medical equipment and physician services, any portion of these sections as well as any portion of 42 CFR 410.20(d), which implements Section 1869(h) of the Act, and 42 CFR 414.234, which implements Section 1834(a)(15) of the Act, will be waived if they could be construed to limit CMS' ability to conduct prior authorization for other items or services or they could be construed to restrict what entity performs said prior authorization.

WISeR Quick Reference for Providers and Suppliers

Starting on January 5, 2026, for dates of service on or after January 15, 2026, select items and services covered under Original Medicare will be subject to prior authorization or pre-payment medical review under the WISeR Model.

The answers to the following two questions determine whether a provider or supplier will be impacted by the WISeR Model. Impacted providers and suppliers will have the option to either complete the prior authorization request or undergo pre-payment medical review prior to claims payment for these items and services:

- Does the supplier or provider practice in Arizona, New Jersey, Ohio, Oklahoma, Texas, or Washington?
- Will the provider or supplier deliver at least one of the WISeR Select Items and Services listed in Appendix A to Original Medicare beneficiaries? Of note, patients with Medicare Advantage and Railroad Medicare beneficiaries are not impacted by the WISeR Model.

If the provider or supplier answers yes to both questions, the provider or supplier is included in the WISeR Model and will have two options to demonstrate medical necessity requirements when delivering WISeR Select Items and Services throughout the model's duration:

1. Submit a prior authorization request for the WISeR item or service directly to the WISeR Participant in their state or to their regularly assigned Medicare Administrative Contractor (MAC).
2. Provide the WISeR item or perform the WISeR service and submit a claim without prior authorization. Claims submitted without prior authorization will be subject to pre-payment

medical review. The WISeR Participant will contact the WISeR Provider or WISeR Supplier to request the relevant clinical documentation related to the claim.

Requests for either option can be sent to the MAC or WISeR Participant by mail, fax, or Electronic Submission of Medical Documentation (esMD), or via the electronic portal.

WISeR does not change Medicare benefits or coverage requirements. The WISeR Participant will use existing National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) and the clinical documentation submitted by the provider or supplier to determine whether to issue a provisional affirmation or non-affirmation for each prior authorization request. The WISeR Participant will also use NCDs and LCDs in combination with the submitted clinical documentation to determine whether the service billed was medically necessary and payable. Determinations are expected to be made within the following time frames:

- For prior authorization requests, WISeR Participants will plan to issue a determination to the requester within 3 calendar days of receiving the initial or resubmitted request. Expedited requests will be completed within 2 calendar days.
- For pre-payment medical review, WISeR Providers and WISeR Suppliers will have 45 calendar days from the date of the request for documentation from the WISeR Participant to submit their clinical documentation. WISeR Participants will issue a determination on medical necessity to the MAC within 3 calendar days of receipt of all documentation.

The WISeR Provider or WISeR Supplier may resubmit the prior authorization request and may include additional information to support the resubmission if they receive a non-affirmation decision. There is no limit to the number of times a particular prior authorization request can be resubmitted. With a resubmission, the requester will also have the opportunity to request peer-to-peer clinical review to inform the new determination. If the pre-payment medical review results in a claim denial, the provider or supplier can appeal the denial using the existing Medicare appeals process. WISeR preserves all Medicare appeals rights for providers and beneficiaries.

Section 1. Model Overview

The Wasteful and Inappropriate Service Reduction (WISeR) Model aims to help ensure people with Original Medicare receive safe, effective, and necessary care. The WISeR Model tests the implementation of technology-enhanced prior authorization and pre-payment medical review for WISeR Select Items and Services in limited geographic regions to help patients and providers avoid unnecessary or inappropriate care while safeguarding federal taxpayer dollars. Importantly, the WISeR Model does not change existing Original Medicare coverage or payment policies, and providers and beneficiaries still retain their rights to appeal any denied claims.

1.1. WISeR Participants

Participants in the WISeR Model are companies with expertise managing prior authorization for other payers using enhanced technology, such as artificial intelligence, to streamline medical review. In this guide, we use the term "WISeR Participants" to refer to these companies. The WISeR Model has six states and six WISeR Participants. Each WISeR Participant has been assigned to manage prior authorization and pre-payment review for WISeR Select Items and Services in one state.

WISeR Participants will work closely with the Centers for Medicare & Medicaid Services (CMS) Medicare Administrative Contractors (MACs) in their assigned states, establishing formal Business Associate Agreements in compliance with the Health Insurance Portability and Accountability Act and privacy laws. WISeR Participants will also work with their assigned MACs to coordinate data flows so that WISeR Providers and WISeR Suppliers are not required to change their usual processes if they choose to submit information directly to MACs.

1.2. WISeR Beneficiaries, WISeR Providers, and WISeR Suppliers

Original Medicare–enrolled providers and suppliers in WISeR Participants' jurisdictions who furnish WISeR Select Items and Services to Original Medicare beneficiaries will be referred to as "WISeR Providers" and "WISeR Suppliers." Railroad Medicare beneficiaries are excluded from the WISeR Model.

WISeR Providers and WISeR Suppliers will have the option to submit prior authorization requests (as detailed in Section 3) for the WISeR Select Items and Services before delivering those WISeR Select Items and Services to WISeR Beneficiaries. A "WISeR Beneficiary" is an individual who is enrolled in Original Medicare and receives WISeR Select Items and Services from a WISeR Provider or WISeR Supplier who provides the item or service in a state that is included in the WISeR Model.

1.3. Prior Authorization and Pre-Payment Medical Review Process

WISeR Providers and WISeR Suppliers who request prior authorization will have their requests processed by their designated WISeR Participant, who will issue a decision (affirmed or non-affirmed), as detailed in Section 4. Non-affirmed decisions may be resubmitted, during which time WISeR Providers and WISeR Suppliers may request peer-to-peer review (see Section 4.4 for additional information).

If WISeR Providers and WISeR Suppliers furnish WISeR Select Items and Services without prior authorization, those claims will be routed to the WISeR Participant for pre-payment medical review,

and the WISeR Participant will request documentation to support the medical necessity of the care before the claim is paid or denied (See Section 7.2).

Throughout the prior authorization and pre-payment medical review processes, WISeR Participants will use appropriately trained clinicians, as applicable, to verify that WISeR Select Items and Services that are requested or furnished meet Medicare coverage criteria. These clinicians will have subject matter expertise relevant to the type of care under review.

1.4. Model Timeline and Scope

The WISeR Model will be implemented on January 1, 2026. WISeR Participants and MACs will not begin accepting prior authorization requests from WISeR Providers and WISeR Suppliers until January 5, 2026. This later date is intentional and is designed to provide sufficient lead time to process requests and ensure adequate time to schedule affirmed services. Please note that prior authorization requests submitted on or after January 5, 2026, will apply to services rendered on or after January 15, 2026. The WISeR Model will run through December 31, 2031.

Six states across four MAC jurisdictions have been selected for the WISeR Model. These states are collectively referred to as "WISeR Jurisdictions":

- New Jersey (JL/Novitas Solutions, Inc.)
- Ohio (J15/CGS Administrators, LLC)
- Oklahoma and Texas (JH/Novitas)
- Arizona and Washington (JF/Noridian)

1.5. Included Items and Services and Sites of Service

The WISeR prior authorization and pre-payment medical review process will apply to the WISeR Select Items and Services list (Appendix A) for services delivered in a state selected for the WISeR Model. These WISeR Select Items and Services were selected based on three key criteria:

1. They have existing, publicly available coverage criteria.
2. They are typically elective, not first-line diagnostics or treatments for a medical condition, and may pose concerns related to patient safety if delivered inappropriately.
3. They are of sufficient volume or dollar value to ensure adequate WISeR Model impact and may involve prior reports of potential fraud, waste, and abuse.

First and foremost, WISeR Participants will follow coding and clinical guidance in the selected National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). For a subset of WISeR Select Items and Services, prior authorization and pre-payment review will be limited to certain indications as specified in the NCDs and LCDs; ICD-10[4] codes for those relevant WISeR Select Items and Services are listed in Appendix B. Additionally, for services that involve a trial before permanent implantation of a device, WISeR will initially implement prior authorization and pre-payment medical review for the permanent implantation only. More information is detailed in Section 6 of this guide.

[4] ICD-10 refers to the International Classification of Diseases and Related Health Problems, 10th Revision.

WISeR does not overlap with existing CMS prior authorization programs (e.g., the Prior Authorization Program for Certain Hospital Outpatient Department [OPD] Services) and excludes any Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes already subject to prior authorization under existing CMS programs. If applicable, providers and suppliers should continue submitting prior authorization requests for those CPT/HCPCS codes (e.g., CPT code 63650) as part of those existing programs.

CMS may update the WISeR Select Items and Services list during the WISeR Model's performance period. The addition of services to the WISeR Model does not alter Medicare benefit or coverage requirements, nor does it create new documentation requirements for WISeR Providers or WISeR Suppliers. Any documentation required for prior authorization consists of information that providers and suppliers are regularly required to maintain for Medicare payment purposes. Although the WISeR Participants or the items and services included in the WISeR Model might change, any changes would be communicated to WISeR Providers and WISeR Suppliers in a timely manner.

The WISeR Model will include items and services rendered at select sites of service, as defined by the Type of Bill (TOB) and/or Place of Service (POS) code. The sites of service included are Hospital OPD (TOB 13X for facility claims, corresponding to POS 19 and 22 on professional claims), Ambulatory Surgery Center (ASC) (POS 24), home (POS 12), and office (POS 11). For items and services delivered in the Hospital OPD and ASC settings, WISeR will include and select facility-based encounters and claims, rather than professional services.

1.6. Inquiries Regarding the Model

Providers and suppliers who have questions about the WISeR prior authorization and pre-payment medical review process should contact the WISeR Participant assigned to their MAC jurisdiction. The WISeR Participant will provide additional education to WISeR Providers and WISeR Suppliers about the prior authorization and medical review process. WISeR Participant contact information is available in Section 3.3. Please also note that the WISeR Help Desk is unable to provide support for an individual participant's portals or verify prior authorization requests.

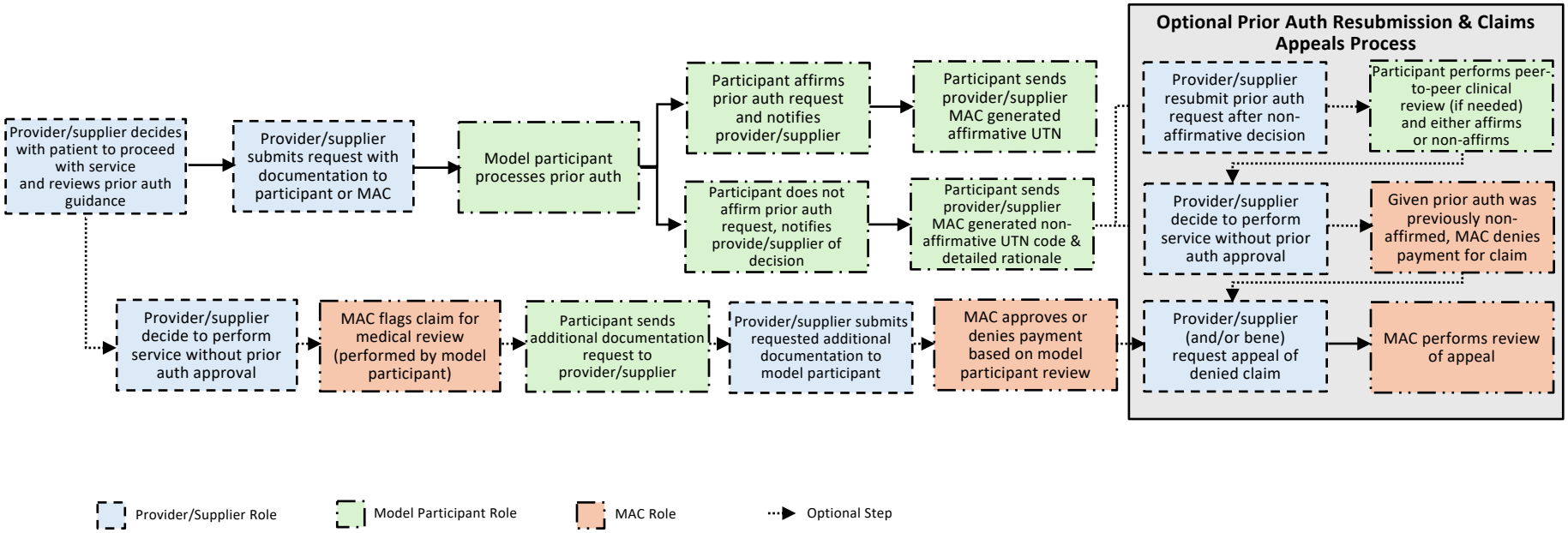
Section 2. Pathways to Coverage Determination Under WISeR

WISeR Providers and WISeR Suppliers will have two options under WISeR to receive coverage determinations:

1. Submit a prior authorization request to receive a determination before administering WISeR Select Items and Services, as described in Sections 3 and 4.
2. Furnish WISeR Select Items and Services immediately and wait for the determination through pre-payment review, as described in Section 7.2.

Figure 1 displays the prior authorization and pre-payment medical review workflow.

Figure 1. WISeR Model workflow



Section 3. Submitting a Prior Authorization Request

Under the WISeR Model, a prior authorization request by the WISeR Provider or WISeR Supplier will result in a provisional affirmation or non-affirmation of Medicare coverage for WISeR Select Items and Services listed in Appendix A. WISeR Providers and WISeR Suppliers will have two options for submitting a prior authorization request:

1. Submit a prior authorization request directly to the WISeR Participant.
2. Submit a prior authorization request to their designated MAC. The MAC will forward the request to the WISeR Participant within 1 calendar day, or as soon as practicable.

Each prior authorization request must:

1. Pertain to one WISeR Select Item or Service in Appendix A.
2. Be submitted in advance of furnishing the item or service to the WISeR Beneficiary and before submitting the claim for processing.
3. Contain a common set of standard data elements listed in Section 3.2.
4. Include all documentation necessary to show compliance with applicable Medicare coverage criteria, including coding, and payment rules. See Section 6 for additional details on the documentation requirements.

If a WISeR Provider or WISeR Supplier intends to bill multiple affirmed services on the same claim in the Hospital OPD setting, the services must be included on the same prior authorization request and have the same unique tracking number (UTN).

Note that in lieu of requesting prior authorization for WISeR Select Items and Services, WISeR Providers and WISeR Suppliers may choose to provide the select item or service without prior authorization and submit the claim for payment. In this case, the MAC will suspend the claim and forward it to the WISeR Participant for pre-payment medical review. See Section 7.2 for additional information on the pre-payment medical review process.

The term “requester” will be used throughout this document to describe the person or entity that submits the prior authorization request, documentation, and/or claims.

3.1. Initial Prior Authorization Requests and Resubmissions

An initial prior authorization submission is the first prior authorization request sent to the WISeR Participant for review and decision.

If the initial prior authorization request is non-affirmed, the requester may submit a subsequent submission (also known as a resubmission) with additional and/or updated documentation to correct an error or omission identified by the WISeR Participant during its initial review.

3.2. General Prior Authorization Request Documentation

Requesters must include the data elements listed in Table 1 in all prior authorization requests to avoid potential processing delays.

Table 1. Required data elements for prior authorization requests

Category	Required data element
WISeR Beneficiary Information (as written on their Medicare card)	• Beneficiary name • Beneficiary Medicare number (also known as the MBI) • Beneficiary date of birth • Beneficiary address • Beneficiary email address (optional)
Facility Information (if applicable)	• Name of facility • Provider Transaction Access Number (PTAN)/CMS Certification Number (CCN) • Facility address • Facility National Provider Identifier (NPI)
Physician/Practitioner Information	• Physician/practitioner name • Physician/practitioner NPI • Physician/practitioner PTAN • Physician/practitioner address • Physician/practitioner fax number (optional) • Physician/practitioner email address (optional)
Requester Information	• Requester name • Requester phone number • Requester email address • Requester fax number
Other Supporting Information	• CPT/HCPCS code(s) for the WISeR Select Item or Service being submitted for prior authorization • Diagnosis code(s) pertinent to the WISeR Select Item or Service • Anticipated Place of Service or facility type • Units of service (to be performed within 120 days of the decision) • Indication of whether the request is an initial review or a resubmission • Indication of whether the request should be expedited to avoid jeopardizing the life or health of the WISeR Beneficiary and the reason for the expedited service • Clinical documentation requirements specific to the selected item or service • Other information as directed by the WISeR Participant

Note: CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

For resubmissions, in addition to the required data elements in Table 1, requesters must also include an exact match of the WISeR Beneficiary's first name, last name, date of birth, and the UTN associated with the previous submission. WISeR Providers and WISeR Suppliers should look at the initial decision notification for the UTN.

3.3. Sending a Prior Authorization Request to the WISeR Participant

Requesters can submit prior authorization requests directly to WISeR Participants. WISeR Providers and WISeR Suppliers are encouraged to use electronic delivery when possible to avoid potential delays with fax and mailing. When submitting prior authorization requests via fax, place the prior authorization form on the page immediately after the fax cover sheet. WISeR Participants' contact information (as of March 12, 2026) is included in Table 2; this table will be maintained and updated throughout the WISeR Model as needed.

Table 2. WISeR Participant contact information

Model participant, website	State	Contact information
Cohere Health, Inc. Link to Cohere Health website	Texas	Telephone: 855-430-6299; fax: 404-835-8325 Email: wiser.support@coherehealth.com Web portal: https://next.coherehealth.com/
Genzeon Corporation Link to Genzeon website	New Jersey	Telephone: 484-713-9291; fax: 484-200-2155 Email: wiserhelpdesk@genzeon.com Web portal: https://portal.hip.one
Humata Health, Inc. Link to Humata Health website	Oklahoma	Telephone: 407-308-0378; fax: 617-843-6857 Email: wiser.support@humatahealth.com Web portal: https://psi.humatahealth.com/login
Innovaccer Inc. Link to Innovaccer website	Ohio	Telephone: 202-796-1619 Email: ohcmswiser-inquiry@innovaccer.com Web portal: https://wiser.innovaccer.us
Virtix Health LLC Link to Virtix Health website	Washington	Telephone: 833-943-2209 Email: wiser.support@virtixhealth.com Web portal: https://wiser.portal.virtixhealth.com/login
Zyter Inc. Link to Zyter Website	Arizona	Telephone: 202-773-1430; fax: 667-407-1889 Email: wiser@zyter.com Web portal: https://zytercms.gov.hosted.health/proauth/sign-in

3.4. Sending a Prior Authorization Request to the MAC

Requesters have the following options for submitting prior authorization requests to the Medicare Part A and Part B MACs (A/B MACs):[5]

1. Fax[6]

[5] A/B MACs process Part A and Part B claims for a defined jurisdiction and service institutional providers, physicians, practitioners, and suppliers. See What's a MAC for more information.

[6] When submitting prior authorization requests via fax, place the prior authorization form on the page immediately after the fax cover sheet.

2. Electronic Submission of Medical Documentation (esMD)[7]
3. Mail
4. MAC electronic portal (A/B MAC specific)

WISeR Providers and WISeR Suppliers are encouraged to use electronic delivery to avoid mailing delays. MAC contact information is included in Table 3.

Table 3. MAC contact information

MAC jurisdiction, state(s), website	Telephone and fax numbers	Mailing address
JF (Noridian Healthcare Solutions LLC) Arizona and Washington Link to Noridian Website	Customer Service: 877-908-8431 Fax: 701-277-7852	Noridian JF Part B PO Box 6700 Fargo, ND 58108-6700
J15 (CGS) Ohio Link to CGS Website	Customer Service: 866-276-9558 Fax: 615-660-5300	CGS Administrators, LLC J15 Part B Correspondence PO Box 20018 Nashville, TN 37202
JL (Novitas Solutions) New Jersey Link to Novitas Solutions Website (JL)	Prior Auth Customer Service: 855-340-5975 Fax: 833-200-9268	Novitas Solutions JL Prior Authorization Requests PO Box 3702 Mechanicsburg, PA 17055
JH (Novitas Solutions) Oklahoma and Texas Link to Novitas Solutions Website (JH)	Prior Auth Customer Service: 855-340-5975 Fax: 833-200-9268	Novitas Solutions JH Prior Authorization Requests PO Box 3702 Mechanicsburg, PA 17055

Section 4. Prior Authorization Review

Once the requester submits the prior authorization request, the WISeR Participant will review the information submitted and issue a prior authorization decision (affirmation or non-affirmation) to the requester.

Each prior authorization request will be assigned a UTN generated by the MAC. If available, the WISeR Participant will share this UTN number with the requester when the WISeR Participant sends the prior authorization determination. **It is possible to receive a determination before the MAC generates a UTN. If this occurs, the requester should wait for the UTN and not resubmit the request until it has been received** (see Sections 3.1 and 3.2 for the required data elements that requesters must include). For questions or further assistance, please contact the participant and/or the MAC (see Sections 3.3 and 3.4 for contact information). WISeR Providers and WISeR Suppliers will need to ensure the UTN is included on each submitted claim if the service is rendered, regardless of whether the prior authorization request determination is an affirmation or non-affirmation (see Section 7 for details on the claim submission process).

[7] For more information about submissions through esMD, see the CMS esMD website or contact the appropriate MAC.

4.1. Prior Authorization Decision Types

4.1.1. Provisional Affirmation

A provisional affirmation is a preliminary finding that a future claim submitted to Medicare for the WISeR Select Item or Service likely meets Medicare's coverage criteria, including coding and payment rules in Chapter IV of Title 42 or in Title XVIII of the Act, and that the WISeR Select Item or Service is appropriate for the WISeR Beneficiary.

The WISeR Participant will issue a provisional affirmation to the requester, with a copy to the WISeR Beneficiary, if it is decided that applicable Medicare coverage, coding, and payment rules are met. In general, the WISeR Participant will aim to send the determination to the requester through the same method the requester originally used to submit the request (e.g., via postmark, fax, or electronic delivery) and within the time frames discussed in Section 4.2. For requests sent directly to the MAC via their MAC-specific electronic portal or esMD, the WISeR Participant will aim to send the determination to the requestor via fax or another means of delivery using the contact information supplied by the requestor.

Provisional affirmation prior authorization decisions are valid for 120 days from the date that the decision was made. Services that are affirmed but not delivered before the 120-day window expires will require a new prior authorization request.

4.1.2. Non-affirmation

A non-affirmation prior authorization decision is a preliminary finding that a future claim submitted to Medicare for the requested item or service likely does not meet Medicare's applicable coverage criteria, including coding and payment rules in Chapter IV of Title 42 or in Title XVIII of the Act, and that the WISeR Select Item or Service is not appropriate for the WISeR Beneficiary.

The WISeR Participant will issue a non-affirmation prior authorization decision to the requester, with a copy to the WISeR Beneficiary if it is decided that applicable Medicare coverage, coding, and payment rules are not met. If the prior authorization review results in a non-affirmed decision, the WISeR Participant will provide detailed information about all missing and/or noncompliant information that led to the decision, as well as instructions for resubmission. In general, the WISeR Participant will aim to send the non-affirmation decision to the requester through the same method the requester originally used to submit the request (e.g., via postmark, fax, or electronic delivery) and within the time frames discussed in Section 4.2. For requests sent directly to the MAC via their MAC-specific electronic portal or esMD, the WISeR Participant will aim to send the determination to the requestor via fax or another means of delivery using the contact information supplied by the requestor.

For non-affirmations, the WISeR Model requires that the WISeR Participant have human clinicians with relevant clinical expertise review the determination before it is issued.

Note that if a prior authorization request includes multiple WISeR item or service codes, the non-affirmation of one item or service will result in the non-affirmation of the entire prior authorization request. Providers and suppliers will be able to submit items and services that meet criteria to be affirmed in a resubmission.

4.1.3. Provisional Partial Affirmation

Effective April 1, 2026, a provisional partial affirmation decision means that one or more services on the prior authorization request received a provisional affirmation decision, and one or more services received a non-affirmation decision.

WISeR Participants will follow the same process for any service(s) within the prior authorization request that receives a provisional affirmation decision, as described in Section 4.1.1, and for any service(s) that receives a non-affirmation decision, as described in Section 4.1.2.

4.1.4. Dismissal

A prior authorization request is dismissed when certain information required to process the request (e.g., MBI) is incomplete or invalid, or when the request does not fall within the scope of WISeR. Duplicate prior authorization requests are also subject to dismissal. A duplicate is a new prior authorization request submitted by the same WISeR Provider/Supplier for the identical WISeR Beneficiary and Select Item or Service before the WISeR Participant has issued a determination for any earlier prior authorization request(s). The model participant will notify the submitter that their request was dismissed and the reason for the dismissal. Dismissed prior authorization requests are not reviewed for medical necessity. When a prior authorization request is dismissed, the submitter should review the reason listed in the dismissal letter. The submitter may then correct the error and submit the request again using the same submission procedures. When sending the corrections, the submitter must include all original documentation. If the dismissed request was an initial request, the subsequent request should be marked as an initial request. Table 4 presents several common dismissal reasons and steps to resolve.

Table 4. Common dismissal reasons and corrective actions

Dismissal reason	Additional explanation	Steps to resolve
The request was submitted to the incorrect WISeR Participant or MAC.	A WISeR Participant and MAC are associated with each state that is in the WISeR Model.	Submit the request to the correct WISeR Participant or MAC responsible for processing requests for the state in which the service is being delivered.
The request is for a non-WISeR service.	Only the items and services defined in Appendix A are subject to prior authorization review under WISeR.	None. The service is not subject to prior authorization review under WISeR.
The beneficiary has a Medicare Advantage Plan or Medicaid.	WISeR applies to Medicare Fee-for-Service beneficiaries.	Contact the individual Medicare Advantage or Medicaid Plan for information on their PARs.
The request contains an invalid, missing, or deceased MBI or beneficiary name.	Providers must include certain data elements in a PAR to be processed.	Submit a new request with the corrected information.

Dismissal reason	Additional explanation	Steps to resolve
Invalid or missing billing information (PTAN, NPI, or TOB code).	Providers must include certain billing information in a PAR to be processed.	Verify the required information and resubmit the PAR.
The PAR was submitted by an ineligible provider.	The WISeR Model only applies to providers and suppliers who meet the criteria described in the WISeR Quick Reference for Providers and Suppliers section, part of the Purpose section.	Render the service and follow your standard billing process.
The PAR was submitted by an exempt provider.	Exempt providers do not need to submit PARs.	Render the service and follow your standard billing process.

Note: CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; MAC = Medicare Administrative Contractor; MBI = Medicare Beneficiary Identifier; NPI = National Provider Identifier; OPD = Outpatient Department; PAR = prior authorization request; PTAN = Provider Transaction Access Number; TOB = Type of Bill; UTN = Unique Tracking Number.

4.2. Review Time Frames

4.2.1 Standard WISeR Prior Authorization Review Time Frame

WISeR Participants will typically issue a determination to the requester within 3 calendar days of receiving the initial or resubmitted request. The determination will be sent in the same manner in which the prior authorization request was submitted (e.g., via postmark, fax, or electronic delivery).

4.2.2. Expedited WISeR Prior Authorization Review

The requester may submit a prior authorization request for expedited review with the applicable documentation if delays could seriously jeopardize the WISeR Beneficiary's life, health, or ability to regain maximum function. If the WISeR Participant confirms this risk, the WISeR Participant will process the prior authorization request and communicate a decision to the requester within 2 days of receipt of the expedited request. If the WISeR Participant does not confirm the risk, the request will be processed under the standard timeframe (as defined in Section 4.2.1), and the WISeR Participant will notify the WISeR Provider or WISeR Supplier of the reclassification to the standard timeframe.

The determination will be sent to the requester in the same manner in which the prior authorization request was submitted (e.g., via postmark, fax, or electronic delivery). To avoid delays with mailing, WISeR Providers and WISeR Suppliers are encouraged to use fax, esMD, or a relevant electronic portal.

In expedited circumstances, the WISeR Participant may issue a determination to the requester before a UTN is generated and assigned to the prior authorization request. To prevent the claim for an affirmed, expedited service from being denied upon submission, the requester should hold their claim and not submit it for payment until the UTN is provided. The MAC will follow the standard process to obtain a UTN from CMS shared systems and then share the UTN with the requester once it is available.

4.3. Validation Period for Prior Authorization Decisions

Once a prior authorization request is approved, the UTN associated with it is valid for 120 calendar days starting from the decision date (the date it was approved). For example, if the prior authorization request is affirmed on January 5, 2026, the prior authorization and associated UTN (which must be included on the claim for the service) will be valid for dates of service through May 4, 2026. Otherwise, the provider will need to submit a new prior authorization request and obtain a new UTN.

For WISeR Select Items or Services (e.g., skin substitutes) when the prior authorization request is affirmed for repeat instances, the same UTN should be submitted with each claim for up to 120 days after the date of determination.

4.4. Resubmissions and Peer-to-Peer Review

Resubmissions are subsequent prior authorization requests submitted after the initial prior authorization request was submitted and reviewed and after the WISeR Participant makes a non-affirmed decision. The requester may submit another complete prior authorization request, including all required documentation and needed modifications, as noted in the detailed decision notification. Unlimited resubmissions are permitted. The requester must include the original non-affirmed UTN on the resubmitted prior authorization request.

When resubmitting a request, the requester may request peer-to-peer clinical review to inform the new determination. Under peer-to-peer review, the WISeR Provider or WISeR Supplier will be connected with a clinician(s) with specialty expertise on the condition under review. The discussion will leverage the applicable NCD or LCD along with the WISeR clinical documentation requirements (see Section 6).

Resubmissions, which could include peer-to-peer review, should be conducted within the standard or expedited time frames specified in Section 4.2.1 or 4.2.2.

4.5. Decision Notification

The requester will receive a notification of the prior authorization determination, including the MAC-generated UTN. This notification will be sent in the same format in which the prior authorization request was originally submitted and within the time frames described in Section 4.2 of this guide.

CMS allows physicians or practitioners to submit the prior authorization request on behalf of a facility. Physicians and practitioners who submit the prior authorization request on behalf of a facility should include their contact information on the request cover sheet, in addition to the facility's contact information. If the physician or practitioner is not the requester and would like to obtain a copy of the decision notification, they should contact the facility.

The WISeR Participant will also send a copy of the notification to the WISeR Beneficiary.

Section 5. Exemption(s)

CMS and WISeR Participants are implementing a process in 2026 to automatically exempt a WISeR Provider or WISeR Supplier from the prior authorization process and pre-payment medical review upon demonstration of compliance with Medicare coverage, coding, and payment rules.

To achieve Exemption Status, a provider must do the following:

1. Submit at least 10 prior authorization requests across WISeR Select Items and Services during an exemption assessment period
2. Achieve a minimum affirmation threshold during an exemption assessment period.

More specifics related to these criteria will be publicly posted by the WISeR Participants in Spring 2026. WISeR Participants will also deliver provider education specific to the Exemption Program. Beginning in June 2026, WISeR Participants will start to issue notifications to WISeR Providers and Suppliers who have been added to the Exemption Status list. WISeR Providers and Suppliers will be added to the Exemption Status list on a quarterly basis. The notification will specify the effective date of Exemption Status and the process for reevaluating Exemption Status.

5.1 Reevaluation of Exemption Status

Exempted WISeR Providers and Suppliers will maintain their status for a defined period of time (e.g., at least a year). WISeR Participants will reevaluate Exemption Status through issuing no more than 10 additional documentation requests (ADRs) per year, examining continued compliance with Medicare coverage criteria. After reevaluation is completed, WISeR Participants will notify any providers who lose Exemption Status at least 60 days before the start of the next quarter. The notification will include the effective date of removal and the process for re-earning Exemption Status.

Section 6. Program Specifics for Selected Items and Services

6.1. Implementation of WISeR Prior Authorization

The WISeR Participants and MACs will begin accepting prior authorization requests for WISeR Select Items and Services starting on January 5, 2026, for services rendered on or after January 15, 2026.

6.2. Required Documentation

To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity of services. Subsections 6.2.1 to 6.2.13 list the documentation requirements for example services.

For detailed documentation requirements, providers who choose to submit a prior authorization request for a WISeR Select Item or Service should refer to the relevant NCDs and/or their MAC jurisdiction's LCDs and Local Coverage Articles (LCAs), if available, for guidance. They can be found on the Medicare Coverage Database website.[8]

[8] Search the Medicare Coverage Database.

WISeR does not change Medicare coding, coverage, or payment criteria and does not interfere with existing processes to reconsider NCDs or LCDs (e.g., when the Food and Drug Administration label for the use of the device has changed). NCDs and LCDs are periodically updated by CMS and/or the MACs, and WISeR will align with the effective version of the NCD or LCD in place at the time of the prior authorization request and/or pre-payment review.

For WISeR services with NCDs that contain broader criteria, WISeR will initially limit implementation to select indications and HCPCS/CPT codes, which can be expanded in the future.

Please note that CMS is delaying the implementation of Deep Brain Stimulation (DBS) in WISeR. As a result, DBS will not be subject to prior authorization or pre-payment review under the WISeR Model when the model began on January 1, 2026. Unlike other WISeR items and services, DBS is commonly delivered as a two-stage procedure, and as of October 2025, the CPT codes for the first stage (e.g., implantation of electrodes, CPT codes 61867 and 61868) are on the Medicare Inpatient Only list. CMS remains committed to excluding services that are delivered solely in the inpatient setting to protect beneficiaries and ensure they receive medically necessary care in the most clinically appropriate setting. CMS will reevaluate implementing prior authorization or pre-payment review of DBS under WISeR in a future model performance year.

CMS is also delaying the implementation of the Percutaneous Image-Guided Lumbar Decompression for Spinal Stenosis (PILD) in WISeR. As a result, PILD will not be subject to prior authorization or pre-payment review under the WISeR Model when the model began on January 1, 2026. Unlike other WISeR items and services at this time, PILD has multiple clinical study approvals under its Coverage with Evidence Development (CED) program, which impacts its operational feasibility. CMS will reevaluate implementing prior authorization or pre-payment review of PILD under WISeR in a future model performance year.

The following WISeR services are subject to prior authorization and pre-payment review if performed in a WISeR Jurisdiction. The HCPCS/CPT codes associated with the following selected items and services are listed in Appendix A.

1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)
2. Induced Lesions of Nerve Tracts (NCD 160.1)
3. Vagus Nerve Stimulation (NCD 160.18)
4. Phrenic Nerve Stimulators (NCD 160.19)
5. Electrical Nerve Stimulators (NCD 160.7)
6. Incontinence Control Devices (NCD 230.10)
7. Sacral Nerve Stimulators for Urinary Incontinence (NCD 230.18)
8. Diagnosis and Treatment of Impotence (NCD 230.4)
9. Percutaneous Vertebral Augmentation for Vertebral Compression Fracture (L34228, L38201, L35130)
10. Epidural Steroid Injections for Pain Management (L39015, L39240, L36920)
11. Cervical Fusion (L39741, L39758, L39793)
12. Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (L38307, L38310, L38385)
13. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041) and Wound Application of Cellular and/or Tissue Based Products (CTPs), Lower Extremities (L36690)

14. Deep Brain Stimulation (NCD 160.24): implementation delayed and will not occur on January 1, 2026; to be reevaluated for implementation in a future performance year
15. Percutaneous Image-Guided Lumbar Decompression for Spinal Stenosis (NCD 150.13): implementation delayed and will not occur on January 1, 2026; to be reevaluated for implementation in a future performance year

6.2.1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)

General documentation requirements for arthroscopic lavage and arthroscopic debridement of the osteoarthritic knee are as follows:

- ❑ Documentation that the patient has less severe and/or early degenerative arthritis and is presenting with symptoms other than pain alone, e.g., mechanical symptoms that include, but are not limited to, catching, locking, snapping, or popping.
- ❑ Documentation to support the patient's knee condition, including but not limited to:
    a) Reports of standing x-rays
    b) Magnetic resonance imaging (MRI) results
    c) Arthroscopy results (in the event of pre-payment review)

6.2.2. Induced Lesions of Nerve Tracts (NCD 160.1)

For this NCD, WISeR will initially focus on neurolytic destruction of the trigeminal nerve. General documentation requirements are as follows:

- ❑ Documentation of diagnosis and evaluation of trigeminal neuralgia, including history (of compatible clinical features and impact on daily function) and imaging, as applicable
- ❑ Documentation of failure of or intolerance to conventional medications (e.g., carbamazepine, oxcarbazepine, gabapentin)
- ❑ Documentation of the clinical rationale (e.g., patient cannot tolerate open surgery, patient does not have signs of neurovascular compromise) supporting the selection of rhizotomy or neurolysis over other surgical options (e.g., microvascular decompression, stereotactic radiosurgery)

6.2.3. Vagus Nerve Stimulation (VNS) (NCD 160.18)[9]

General documentation requirements for initial implantation[10] of vagus nerve stimulation (VNS) for the treatment of medically refractory partial onset seizures are as follows:

- ❑ Documentation of medically refractory partial onset seizures with failure of or intolerance to trial(s) of single or combination antiepileptic therapy
- ❑ Documentation with rationale that the patient is not a candidate for epilepsy surgery, has failed epilepsy surgery, or refuses epilepsy surgery after shared decision-making

[9] Prior authorization and pre-payment medical review for Vagus Nerve Stimulation will only be implemented for the indications specified in Appendix B.

[10] WISeR will initially focus on initial implantation of VNS. Revisions and replacements are out of scope of WISeR, but this may be subject to change in the future. As per Section D of NCD 160.18, patients implanted with a VNS device for TRD may receive a VNS device replacement if it is required due to the end of battery life or any other device-related malfunction.

General documentation requirements for initial implantation[11] of VNS for treatment-resistant depression (TRD) through CMS' Coverage with Evidence Development (CED)[12] are as follows:

- ❑ Enrollment in an active CMS-approved trial associated with this NCD/CED
- ❑ Documentation of a major depressive disorder (MDD) episode for at least 2 years or at least four episodes of MDD, including the current episode
- ❑ Documentation of a minimum criterion of four prior failed treatments of adequate dose and duration, as measured by a tool designed for this purpose
- ❑ Documentation of a major depressive episode (MDE) as measured by a guideline-recommended depression scale assessment tool on two visits, within a 45-day span prior to implantation of the VNS device
- ❑ Documentation of a stable medication regimen for at least 4 weeks before device implantation
- ❑ Documentation that none of the following criteria are present:
    a) Current or lifetime history of psychotic features in any MDE
    b) Current or lifetime history of schizophrenia or schizoaffective disorder
    c) Current or lifetime history of any other psychotic disorder
    d) Current or lifetime history of rapid cycling bipolar disorder
    e) Current secondary diagnosis of delirium, dementia, amnesia, or other cognitive disorder
    f) Current suicidal intent
    g) Treatment with another investigational device or investigational drugs

6.2.4. Phrenic Nerve Stimulator (NCD 160.19)

For hypoventilation caused by respiratory paralysis resulting from lesions of the brainstem and cervical spinal cord (interruption of neuronal conduction at or above the C3 vertebral level), congenital central hypoventilation syndrome, and other disorders with ventilatory insufficiency (in which there is dependence on intermittent or permanent use of a mechanical ventilation as well as maintenance of a permanent tracheotomy stoma), the general documentation requirements for initial implantation of a phrenic nerve stimulator are as follows:

- ❑ Documentation of the etiology of ventilatory insufficiency as well as evaluation (e.g., of diaphragmatic function) and management to date, including the use of mechanical ventilation
- ❑ Documentation of intact phrenic nerve and diaphragmatic function, e.g., through a percutaneous nerve conduction study
- ❑ Documentation of absence of severe underlying primary pulmonary disease through history and exam, prior and current chest imaging, and pulmonary function testing (when feasible)

[11] WISeR will initially focus on initial implantation of VNS. Revisions and replacements are out of scope of WISeR, but this may be subject to change in the future. As per Section D of NCD 160.18, patients implanted with a VNS device for TRD may receive a VNS device replacement if it is required due to the end of battery life or any other device-related malfunction.

[12] Centers for Medicare & Medicaid Services. (2024). *Vagus nerve stimulation (VNS) for treatment resistant depression (TRD).*

For central sleep apnea (CSA), the general documentation requirements for initial implantation of a phrenic nerve stimulator are as follows:

- ❑ Documentation of etiology of CSA as idiopathic/primary or heart-failure–related CSA (not opioid- or medication-induced)
- ❑ Documentation of moderate to severe CSA confirmed by polysomnography
- ❑ Documentation of failure of, intolerance of, or contraindication to at least one of the following:
    a) Continuous positive airway pressure (CPAP)
    b) Bilevel positive airway pressure (BiPAP)
    c) Adaptive servo-ventilation (ASV)
    d) Nocturnal oxygen (for patients who have hypoxemia while sleeping)
- ❑ For patients with heart failure (HF): documentation of New York Heart Association (NYHA) class, left ventricular ejection fraction (LVEF), and stable, optimized guideline-directed medical therapy (GDMT) as applicable
- ❑ Documentation of plan for device interaction testing if patient has an implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT), or pacemaker
- ❑ Assessment and documentation of none of the following contraindications:
    a) Active infection
    b) NYHA IV HF or American College of Cardiology (ACC)/American Heart Association (AHA) Stage D
    c) Recent stroke/transient ischemic attack (TIA)
    d) Currently on renal dialysis or severe renal disease
    e) Phrenic nerve palsy or other anatomic barriers
    f) Opioid or other medication-induced CSA

6.2.5. Electrical Nerve Stimulators (NCD 160.7)

For this NCD, WISeR will initially focus on spinal cord stimulators but will not overlap with or include CPT code 63650 for percutaneous implantation of spinal neurostimulators in CMS' Prior Authorization Program for Certain Hospital Outpatient Department (OPD) Services.[13]

Prior authorization and pre-payment review are being implemented for the permanent implantation procedure. A trial procedure should be done, and documentation should be submitted for permanent implantation of a stimulator device.

General documentation requirements for laminectomy for the implantation of a spinal cord stimulator for the relief of chronic intractable pain are as follows:

- ❑ Documentation of condition requiring procedure and applicable physical exam
- ❑ Documentation that stimulation is being used only as a late resort (if not a last resort) for patients with chronic intractable pain, including but not limited to at least one treatment tried and failed (or documentation that they were contraindicated):
    a) Medications

[13] CPT code 63650 for implanted spinal stimulator is included in CMS' Prior Authorization Program for Certain Hospital Outpatient Department Services. For more information, please visit the Prior Authorization for Certain Hospital Outpatient Department Services webpage.

b) Physical therapy
c) Injections
d) Spine surgery
e) Cognitive behavioral therapy

- ❑ Documentation showing that the patient was evaluated by a multidisciplinary team (including psychological,[14] surgical, medical, and physical therapy)
- ❑ Documentation showing that the patient achieved demonstrated 50% reduction in pain relief and evidence of functional restoration with a temporarily implanted electrode
- ❑ Documentation that the patient is not a candidate for percutaneously placed leads (e.g., previous instrumentation, challenging anatomy, high body mass index (BMI), other technical challenges), as WISeR does not include CPT 63650 for the trial or permanent implantation of spinal neurostimulators via the percutaneous approach.[15]

6.2.6. Incontinence Control Devices (NCD 230.10)

NCD 230.10 provides Medicare coverage and payment criteria for the use of mechanical/hydraulic incontinence control devices and collagen implants or injections. Given urethral bulking agents no longer contain collagen (as Contigen® has been discontinued), WISeR initially will focus on mechanical/hydraulic incontinence control devices for the purposes of treating Stress Urinary Incontinence (SUI).

General documentation requirements for mechanical/hydraulic incontinence control devices are as follows:

- ❑ Documentation of evaluation and diagnosis of SUI, such as but not limited to:
  a) Relevant history, in particular, elements that may impact placement of an incontinence control device such as prior prostate or pelvic surgery, pelvic radiation therapy, or urethral trauma (resulting in damage to the urethral sphincter), if applicable
  b) Physical examination, including pelvic or rectal exam, if applicable
  c) Urinalysis: Patients with an abnormal urinalysis, such as unexplained hematuria or pyuria, should undergo additional evaluation if being considered for surgical intervention.
  d) Result of a cough or bladder stress test or an objective demonstration of urinary incontinence with a comfortably full bladder
  e) Additional testing, if applicable
     - Voiding diary (at least 24 hours of symptoms)
     - Cystoscopy where there is a concern for urinary tract abnormalities
     - Urodynamic testing for complicated or mixed symptoms (e.g., patients with mixed incontinence in whom the predominant contributor is unclear)

[14] See Medicare Learning Network (MLN1986542) booklet and Publication #100-2, Chapter 15, for more information on psychological evaluations.

[15] CPT code 63650 for implanted spinal stimulator is included in CMS' Prior Authorization Program for Certain Hospital Outpatient Department Services. For more information, please visit the Prior Authorization for Certain Hospital Outpatient Department Services webpage.

f) Assessment and exclusion of other etiologies of urinary incontinence (e.g., known or suspected urinary tract infection, high post-void residual volume concerning for overflow incontinence, high-grade pelvic organ prolapse if SUI is not demonstrated by pelvic organ prolapse reduction)

- ❑ Documentation of adjunctive measures and treatments tried and failed (or contraindicated), such as but not limited to:
    a) Lifestyle modifications (e.g., addressing contributory medical conditions, limiting alcohol and caffeine consumption, weight reduction if overweight, modifying fluid intake)
    b) Pelvic floor muscle training (± biofeedback)
    c) Low-dose vaginal estrogen for patients with genitourinary syndrome of menopause (GSM) or evidence of hypoestrogenism by history or exam
    d) Support devices (e.g., continence pessaries, vaginal inserts, penile clamps)
    e) Prior surgery for SUI
- ❑ Documentation for any planned concomitant procedures that may affect outcomes associated with placement of an incontinence control device (e.g., patients should not undergo concomitant urethral diverticulectomy, repair of urethrovaginal fistula, or urethral mesh excision and stress incontinence surgery with the exception of placement of autologous slings)

6.2.7. Sacral Nerve Stimulation for Urinary Incontinence (NCD 230.18)[16]

Prior authorization and pre-payment review are being implemented for the permanent implantation procedure. A trial procedure should be done, and documentation should be submitted for permanent implantation of a stimulator device.[17] Please note that lead replacement billed under CPT code 64561 does not require prior authorization or pre-payment review under WISeR, as NCD 230.18 does not explicitly address replacements.

General documentation requirements for a permanently implanted sacral nerve stimulator for the treatment of urinary urge incontinence, urgency-frequency syndrome, or urinary retention are as follows:

- ❑ Documentation of the relevant diagnosis (e.g., urge incontinence, urgency-frequency syndrome, or urinary retention)
    a) Of note, urinary voiding dysfunction should not be a secondary manifestation of specific neurologic diseases (e.g., diabetes with peripheral nerve involvement), stress incontinence, or urinary (e.g., bladder outlet) obstruction.
- ❑ Documentation of treatments tried and failed (or contraindications), such as but not limited to:
    a) Behavioral therapy (e.g., bladder training, pelvic floor rehabilitation)
    b) Pharmacologic therapy
    c) Surgical corrective therapy (e.g., augmentation cystoplasty)

[16] Prior authorization and pre-payment medical review for Sacral Nerve Stimulation for Urinary Incontinence will only be implemented for the indications specified in Appendix C.

[17] During pre-payment review, the billing of a generator implantation code (CPT code 64590) will be used to differentiate between a trial and permanent implantation (billed using CPT code 64561).

- ❑ Documentation that the patient is capable of demonstrating adequate ability to record voiding diary data such that the clinical results of the implant procedure can be properly evaluated
- ❑ Documentation that the patient had a successful test stimulation, as demonstrated by 50% or greater improvement (as measured through voiding diaries)

6.2.8. Diagnosis and Treatment of Impotence (NCD 230.4)

NCD 230.4 provides Medicare coverage and payment criteria for the diagnosis and treatment of impotence. WISeR initially will implement prior authorization for the insertion of penile prostheses (CPT codes 54400, 54401, and 54405). General documentation requirements are as follows:

- ❑ Documentation of evaluation and diagnosis of erectile dysfunction (e.g., testosterone level if a patient has signs or symptoms concerning for hypogonadism)
- ❑ Treatments tried and failed (or contraindicated), such as but not limited to addressing reversible etiologies:
    a) Oral medications, e.g., phosphodiesterase-5 (PDE-5) inhibitors
    b) Intracavernosal injection
    c) Vacuum-assisted erection device
    d) Psychotherapy (for psychogenic erectile dysfunction)
    e) Testosterone replacement therapy (for patients with testosterone deficiency)
- ❑ Absence of systemic infection, active urogenital infection, and/or active skin infection in the region of surgery

6.2.9. Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L34228, L38201, L35130)

General documentation requirements for Percutaneous Vertebroplasty Augmentation (PVA) (Percutaneous Vertebroplasty [PVP] or Kyphoplasty [PKP]) are as follows:

- ❑ For painful, debilitating, osteoporotic, vertebral, collapse/compression fractures, the following requirements should be met:
    a) Acute (less than 6 weeks) or subacute (6 to 12 weeks) osteoporotic VCF (T1–L5) based on symptom onset and documented by advanced imaging (bone marrow edema on MRI or bone-scan/single-photon emission computed tomography (SPECT)/computed tomography (CT) uptake)
    b) Hospitalized with severe pain, defined as a Numeric Rating Scale (NRS) or Visual Analog Scale (VAS) pain score greater than or equal to 8 **OR** non-hospitalized with moderate to severe pain, defined as a NRS or VAS pain score greater than or equal to 5, despite optimal non-surgical management (e.g., narcotic and/or non-narcotic medication, physical therapy modalities), with and without methods of immobility (e.g., rest, bracing). For non-hospitalized patients, one of the following must be documented:
        - Worsening pain **OR**
        - Stable to improved pain (but NRS or VAS score remains greater than or equal to 5), with at least 2 of the following:
            1. Progression of vertebral body height loss
            2. More than 25% vertebral body height reduction
            3. Kyphotic deformity

4. Severe impact of VCF on daily functioning, indicated by a Roland Morris Disability Questionnaire (RDQ) score greater than 17

c) Documentation of referral for evaluation of bone mineral density and osteoporosis education for subsequent treatment as indicated
d) Documentation of instruction to participate in an osteoporosis prevention/treatment program

- ❑ For malignant vertebral fracture, documentation that the patient has an osteolytic vertebral, metastasis, or myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone
- ❑ Assessment and documentation of none of the following:
  a) Current back pain is *not* primarily due to the identified acute or subacute VCF(s)
  b) Osteomyelitis, discitis, or active systemic or surgical site infection
  c) Pregnancy
- ❑ Assessment of the following relative contraindications and rationale for proceeding with PVA if one or more of the following exist:
  a) Greater than three vertebral fractures per procedure
  b) Allergy to bone cement or opacification agents
  c) Uncorrected coagulopathy
  d) Spinal instability
  e) Myelopathy from the fracture
  f) Neurologic deficit
  g) Neural impingement
  h) Fracture retropulsion/canal compromise

6.2.10. Epidural Steroid Injections for Pain Management (L39015, L39240, L36920)[18]

Prior authorization and pre-payment review are being implemented for CPT code 62323 only when used for Epidural Steroid Injections (ESI). Please note that CPT code 62323 does not require prior authorization or pre-payment review under WISeR when submitted for indications other than specified in the selected LCDs, including but not limited to implantation of an intrathecal pump for treatment of pain or spasticity.

General documentation requirements for ESI for pain management are as follows:

- ❑ Documentation of history, physical examination, and radiological testing demonstrating one of the following:
  a) Lumbar, cervical, or thoracic radiculopathy; radicular pain and/or neurogenic claudication due to disc herniation; osteophyte or osteophyte complexes; severe degenerative disc disease, producing foraminal or central spinal stenosis; **OR**
  b) Post-laminectomy syndrome (persistent or recurrent spinal pain after a prior spine surgery); **OR**
  c) Acute herpes zoster–associated pain; AND
- ❑ Documentation that radiculopathy, radicular pain, and/or neurogenic claudication is severe enough to greatly impact quality of life or function, including documentation that an objective

[18] Please reference the associated LCD Reference Articles for the selected LCDs for more information about ICD-10 codes that support medical necessity for this service as defined by the MAC.

pain scale or functional assessment was performed at baseline (prior to interventions) and that the same scale was repeated at each follow-up for assessment of response; AND

- ❑ Documentation of pain duration of at least 4 weeks and the inability to tolerate noninvasive conservative care **OR** medical documentation of failure to respond to 4 weeks of noninvasive conservative care **OR** acute herpes zoster refractory to conservative management where a 4-week wait is not required
- ❑ Documentation of anticipated number of ESI sessions (four or less) per spinal region in a rolling 12-month period. For repeat sessions, documentation of at least 50% sustained improvement in pain and/or function from baseline on the same scale for at least 3 months
    - Of note, if the first ESI underperforms, a repeat session after 14 days may be done with a different approach/level/medication and a clear rationale
- ❑ If applicable: In exceptional and unique cases, documentation establishing the patient-specific need for moderate or deep sedation, general anesthesia, or monitored anesthesia care, as these are generally not required for the procedure.
- ❑ Documentation of the type of image guidance (fluoroscopy or CT with contrast) to be used. If the patient has a documented contrast allergy or pregnancy, ultrasound guidance without contrast may be considered.
- ❑ Documentation of the planned approach, including targeted level(s) and region(s)
    - Of note, transforaminal ESIs (TFESIs) up to two levels in one spinal region; interlaminar ESIs or caudal ESIs up to one level in one spinal region; and bilateral TFESI only when clinically indicated (e.g., documented bilateral foraminal stenosis or central herniation affecting both roots) are considered medically reasonable and necessary.
- ❑ Documentation that the ESI is performed in conjunction with conservative treatments, such as but not limited to:
    - Medication
    - Physical therapy
    - Spinal manipulation therapy
    - Cognitive behavioral therapy
    - Home exercise program
- ❑ Documentation that the patient is part of an active rehabilitation program, home exercise program, or functional restoration program
- ❑ Assessment and documentation of none of the following contraindications:
    - Active localized spinal infection or systemic infection
    - Compressive lesions of the spinal cord
    - Conus medullaris or cauda equina

6.2.11. Cervical Fusion (L39741, L39758, L39793)

Select cervical fusion procedure codes are included in CMS' Prior Authorization Program for Certain Hospital OPD Services.[19] WISeR will initially focus on CPT code 22554, which is not included in CMS' Hospital OPD program.

General documentation requirements for cervical fusion for the decompression or stabilization of the cervical spine are as follows:

- ❑ For traumatic injuries, including fractures, dislocations, fracture-dislocations, or traumatic ligamentous disruption, documentation of:
    a) Fractures or dislocations that are likely to result in spinal instability without neurological defects; **OR**
    b) Fractures or dislocations associated with neurological defects at the affected level; **OR**
    c) Presence of instability
- ❑ For spinal tumors involving the spine or spinal canal, documentation of:
    a) Malignant or benign tumors that have caused instability or neurologic deficit where treatment of the tumor will likely require stabilization of the spine; **OR**
    b) Expected treatment of the tumor, whether by chemotherapy or radiation therapy or surgery, will likely cause spinal instability or neurologic deficits; **OR**
    c) Presence of instability
- ❑ For infection involving the spine in the form of discitis, osteomyelitis, or epidural abscess, documentation of:
    a) Imaging or other studies (MRI, biopsy, bone aspirate) demonstrating infection **AND**
    b) Imaging evidence of vertebral body destruction *or* documentation that spinal debridement will cause vertebral instability; **OR**
    c) Presence of instability
- ❑ For deformities that include the cervical spine, documentation of:
    a) Cervical kyphosis associated with cord compression or atlantoaxial (C1–C2) subluxation or basilar invagination of the odontoid process into the foramen magnum; *or* subaxial (C2–T1) instability kyphosis, head drop syndrome, post-laminectomy deformity; **OR**
    b) Symptomatic pseudarthrosis (non-union of prior fusion) with radiological (e.g., CT or MRI) demonstration of non-union of prior fusion (lack of bridging bone or abnormal motion at fused segment) after 12 months since fusion surgery *or* with radiographic evidence of hardware failure (fracture or displacement); **OR**
    c) Spinal instability after laminectomy; **OR**
    d) Rheumatoid arthritis with associated instability; **OR**
    e) Cervical degenerative spondylolisthesis with spinal instability (anterolisthesis/posterolisthesis) **AND**
    f) Presence of substantial functional limitation, such as severe neck pain or difficulty ambulating or decreased ability to perform Activities of Daily Living or ability to maintain forward gaze **OR**
    g) Progression of deformity

[19] CPT codes 22551 and 22552 for cervical fusion are included in CMS' Prior Authorization Program for Certain Hospital Outpatient Department Services. For more information, please visit the Prior Authorization for Certain Hospital Outpatient Department Services webpage.

6.2.12. Hypoglossal Nerve Stimulation (HGNS) for Obstructive Sleep Apnea (L38307, L38310, L38385)[20]

General documentation requirements for the implantation of a hypoglossal nerve stimulator for obstructive sleep apnea are as follows — the following requirements should be met:

- ❑ Age 22 or older
- ❑ BMI is less than 35 kg/m^2
- ❑ Results of polysomnography performed within 24 months of first consultation of HGNS implant (include date of first consultation of HGNS implant and date of polysomnography test) showing:
    a) Predominantly obstructive events (defined as central and mixed apneas less than 25% of the total apnea-hypopnea index [AHI]) **AND**
    b) AHI is 15 to 65 events per hour
- ❑ Documentation demonstrating one of the following:
    - Continuous positive airway pressure (CPAP) failure (defined as AHI greater than 15 events per hour, despite CPAP usage) **OR**
    - CPAP intolerance (defined as less than 4 hours per night, 5 nights per week, or CPAP has been returned), including shared decision-making that the patient was intolerant of CPAP despite consultation with a sleep expert
- ❑ Drug-induced sleep endoscopy (DISE) procedure showing absence of complete concentric collapse at the soft palate level
- ❑ Documentation of any other anatomical findings that would compromise performance of device, e.g., tonsil size 4 per standardized tonsillar hypertrophy grading scale, laryngeal abnormalities that would cause a fixed obstruction (e.g., supraglottic stenosis, post-radiation fibrosis, laryngoceles, anterior cervical osteophytes impinging or pushing on the posterior pharynx)
- ❑ Documentation of counseling regarding future MRI utilization (depending on model implanted)
- ❑ Assessment and documentation of none of the following contraindications:
    a) Central and mixed apneas compromising more than one-quarter of the total AHI
    b) Another implantable device that could result in an unintended interaction with the HGNS implant system (e.g., pacemakers, implantable cardioverter-defibrillators, other nerve stimulators)
    c) BMI equal to or greater than 35 kg/m^2
    d) Neuromuscular disease
    e) Hypoglossal-nerve palsy
    f) Severe restrictive or obstructive pulmonary disease
    g) Moderate-to-severe pulmonary arterial hypertension
    h) Severe valvular heart disease

[20] Prior authorization and pre-payment medical review for HGNS will be implemented for the primary codes specified in Appendix A. As published in the MLN Connects® Newsletter on January 22, 2026, WISeR does not include CPT 64568 billed with ICD-10 code G47.33 (obstructive sleep apnea). Providers with questions about billing for HGNS should contact their respective MAC.

i) New York Heart Association class III or IV heart failure
j) Recent myocardial infarction or severe cardiac arrhythmias (within the past 6 months)
k) Persistent uncontrolled hypertension despite medication use
l) An active, serious mental illness that reduces the ability to carry out Activities of Daily Living and would interfere with the patient's ability to operate the HGNS device and report problems to the attending provider
m) Coexisting non-respiratory sleep disorders that would confound functional sleep assessment
n) Patient is or plans to become pregnant
o) Patient is unable or does not have the necessary assistance to operate the sleep remote
p) Patient has a condition or procedure that has compromised neurological control of the upper airway

6.2.13. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041) and Wound Application of CTPs, Lower Extremities (L36690) [21] [22]

General documentation requirements for the application of a skin substitute or cellular and/or tissue product (CTP) in the treatment of diabetic foot ulcer(s) (DFU) and venous leg ulcer(s) (VLU) are as follows:

- ❑ Description of the wound or ulcer at baseline (prior to beginning standard of care [SOC] treatment) relative to size, location, stage, duration, and presence of infection, as well as progression throughout treatments tried
- ❑ Documentation of the following related to the wound or ulcer:
    a) Partial- or full-thickness ulcers, not involving tendon, muscle, or joint capsule or exhibiting exposed bone or sinus tracts, have a clean granular base unless the CTP package label indicates the CTP is approved for use involving tendon, muscle, or joint capsule or exhibiting exposed bone or sinus tracts, with a clean granular base
    b) Skin deficit at least 1.0 square cm in size
    c) Clean and free of necrotic debris or exudate
    d) Adequate circulation/oxygenation to support tissue growth/wound healing, as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure >30 mmHg)
    e) For DFUs, a diagnosis of Type 1 or Type 2 diabetes along with medical management for this condition
- ❑ Documentation addressing the circumstances why the wound or ulcer has had a "failed response," defined as having failed to respond to documented appropriate wound-care measures, having increased in size or depth, or having not changed in baseline size or depth

[21] Prior authorization and pre-payment medical review will be implemented if it meets the requirements for the codes in Appendix A and ICD-10 diagnosis code for diabetic and venous leg ulcers specified in Appendix B.
[22] Skin substitutes are currently not subject to prior authorization under WISeR for providers in MAC jurisdiction JF. WISeR participants must adhere to the NCDs and LCDs that are currently active in their respective state, participants in MAC jurisdiction JF (Noridian) will not proceed with prior authorization and/or prepayment review of skin substitutes as the LCD has been withdrawn. This change does not impact LCDs for skin substitutes already in effect before January 1, 2026.

with no indication that improvement is likely (such as granulation, epithelization, or progress toward closing), including but not limited to:

a) Interventions that failed
b) Updated medication history
c) Review of pertinent medical problems that may have occurred since previous wound or ulcer evaluations
d) For a neuropathic DFU, documentation of failure to respond to conservative wound-care measures of greater than 4 weeks, during which the patient is compliant with recommendations, and without evidence of underlying osteomyelitis or nidus of infection
e) For a venous stasis ulcer present for at least 3 months, documentation of failure to respond to appropriate wound care for at least 30 days with documented compliance
f) For a full-thickness skin loss ulcer that is the result of abscess, injury, or trauma, documentation of failure to respond to appropriate control of infection, foreign body, tumor resection, or other disease process for a period of 4 weeks or longer

- ❑ Documentation that therapy has resolved any infection and/or underlying osteomyelitis with documentation of the conditions that have been treated and resolved, as applicable:
  a) Control of edema, venous hypertension, or lymphedema
  b) Control of any nidus of infection or colonization with bacterial or fungal elements
  c) Elimination of underlying cellulitis, osteomyelitis, foreign body, or malignant process
  d) Appropriate debridement of necrotic tissue or foreign body (exposed bone or tendon)
  e) For DFUs, appropriate non-weight-bearing or off-loading pressure
  f) For venous stasis ulcers, compression therapy provided with documented diligent use of multilayer dressings, compression stockings of greater than 20 mmHg pressure, or pneumatic compression
  g) Provision of wound environment to promote healing (protection from trauma and contaminants, elimination of inciting or aggravating processes)
- ❑ Documentation of smoking history and that the patient has received counseling on the effects of smoking on outcomes and treatment for smoking cessation (if applicable)
- ❑ Documentation of choice of skin substitute graft product
- ❑ Documentation of expected number of applications over a 12-week period. Of note, simultaneous use of more than one product for the episode of wound is not covered. Product change within the episode of wound is allowed, not to exceed the 10-application limit per wound per 12-week period of care
- ❑ Assessment and documentation of none of the following:
  a) Partial thickness loss with the retention of epithelial appendages is not a candidate for grafting or replacement, as epithelium will repopulate the deficit from the appendages, negating the benefit of overgrafting
  b) Prior utilization of skin substitute grafts when a previous full course of applications was unsuccessful within 1 year. Unsuccessful treatment is defined as:
     - Increase in size or depth of an ulcer or no change in baseline size or depth **AND**
     - No sign of improvement or indication that improvement is likely (such as granulation, epithelialization, or progress toward closing) for a period of 4 weeks past start of therapy

c) Retreatment of healed ulcers (those showing greater than 75% size reduction and smaller than 0.5 square cm)
d) Patient has inadequate control of underlying conditions or exacerbating factors (e.g., uncontrolled diabetes, active infection, active Charcot arthropathy of the ulcer extremity, vasculitis, or continued tobacco smoking without physician attempt to address smoking cessation)
e) Known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, equine products)

Section 7. Claim Submission

Please note that for services rendered in the Hospital OPD or ASC settings, the UTN should be submitted with the facility-based claim.

7.1. General Claims Submission Requirements

When a prior authorization request was submitted and a provisional affirmation or non-affirmation prior authorization decision was granted for an institutional claim processed through the Fiscal Intermediary Shared System (FISS) (e.g., facility-based claims from the Hospital OPD setting), the following requirements apply:

- The submission of the prior authorized claim is to have the 14-byte UTN that is located on the decision notification. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the FISS, the UTN will move to positions 19 through 32, and zeros will autofill the first field. For requesters submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the Treatment Authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.
- For all other submissions, the requester must tab to the second field of the Treatment Authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1–18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS will change the code to zeros, and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN but will be edited for the UTN.
- Claims must include no more than one UTN and should be submitted to the applicable MAC for adjudication.

When a prior authorization request was submitted and a provisional affirmation or non-affirmation prior authorization decision was granted for a professional claim processed through the Multi-Carrier System, the following requirements apply:

- When submitting an electronic 837 professional claim for a prior authorized service, the UTN must be submitted in the 2300 Claim Information loop in the prior authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop. This is in accordance with the requirements of the ASC X12 837 Technical Report 3 (TR3).

- When submitting a paper CMS 1500 Claim form for a prior authorized service, the UTN must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.
- Claims should be submitted to the applicable MAC for adjudication.

7.1.1. Claims Submitted With an Affirmed Prior Authorization Decision on File

If all Medicare coverage, coding, and payment requirements are met, the claim will likely be paid. However, claims submitted with a provisional affirmation may be denied based on either of the following:

- Technical requirements that can only be evaluated after the claim has been submitted for formal processing
- New information becoming available that was not present at the time of the prior authorization request that would otherwise have caused a non-affirmation decision

Claims for which there is a provisional affirmation prior authorization decision on file will be afforded some protection from future audits, both pre- and post-payment; however, review contractors may audit claims if potential fraud, inappropriate utilization, or changes in billing patterns are identified.

7.1.2. Claims Submitted With a Non-Affirmed Prior Authorization Decision on File

If the claim is submitted to the MAC for payment with a non-affirmative prior authorization decision on file, it will be denied. All appeal rights would then available. This claim could then be submitted to secondary insurance, if applicable.

7.2. Pre-Payment Medical Review for Claims Submitted Without a Prior Authorization Decision on File

Submitting prior authorization requests for WISeR Select Items and Services is voluntary; however, if a claim for a WISeR Select Item or Service is submitted without a prior authorization request decision on file, the MAC will suspend the related claim and re-route it to the WISeR Participant to conduct pre-payment medical review. Note that requesters do not need to do anything different when submitting a claim for a WISeR Select Item or Service without a prior authorization decision or UTN on file. They do not need to put any information in the remarks field or submit any unsolicited documentation at the time of claim submission.

Under pre-payment review, the WISeR Participant will contact the billing WISeR Provider or WISeR Supplier for medical record documentation to support the claim. The billing WISeR Provider or WISeR Supplier will have 45 days to respond to the ADR. For OPDs and ASCs, the ADR will be sent to the billing facility, rather than the physician or practitioner who may have submitted the prior authorization request on behalf of the OPD or ASC.

Following receipt of all medical record information, the WISeR Participant will leverage enhanced technology and clinicians, as applicable, to verify the intended use of the WISeR Select Item or Service, the medical necessity, and alignment with Medicare coverage policies and clinical documentation requirements.

The WISeR Participant will issue a decision to the MAC within 3 days following receipt of all requested documentation. The MAC will then pay or deny the claim based on the pre-payment medical review decision.

Please note that if the WISeR Provider or WISeR Supplier does not respond to the ADR within 45 days, the MAC will be notified by the WISeR Participant and will deny the related claim.

7.3. Payment for Associated Items Services

Claims related to or associated with a WISeR Select Item or Service will not be paid if the WISeR Select Item or Service is non-affirmed during prior authorization or denied payment during claims processing. Associated items and services include anesthesiology services involved during the procedure, devices implanted during implantation surgery, physician services, and/or facility services. Depending on the timing of claim submission for any associated items and services, claims may be automatically denied or denied on a post-payment basis.

Although associated items and services do not undergo prior authorization, these items and services will be approved during claim review if either of the following describes the primary service:

- Submitted for prior authorization and affirmed
- Not submitted for prior authorization, but the claim was approved

Associated items and services will be denied if either of the following describes the primary service:

- Submitted for prior authorization and non-affirmed
- Not submitted for prior authorization, but the claim was denied

The codes for associated items and services are listed in Appendix C. This list is subject to change.

Section 8. Special Claim Considerations

8.1. Advance Beneficiary Notice of Non-Coverage (ABN)

If the WISeR Provider or WISeR Supplier receives a non-affirmed prior authorization decision because the service was determined to be not medically reasonable and necessary, the WISeR Provider or WISeR Supplier should issue an Advance Beneficiary Notice of Non-Coverage (ABN) in advance of performing the service if payment is expected to be denied. The WISeR Provider or WISeR Supplier should submit the claim with the GA modifier appended to it. The MAC will determine the validity of the ABN in accordance with standard ABN policies. (See CMS' Internet-Only Manual (IOM) 100-04, Chapter 30.)[23]

If an applicable claim is submitted without a prior authorization decision and is flagged as having an ABN, it will be stopped to request additional documentation, and a review of the ABN will be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The WISeR Provider or WISeR Supplier should issue an ABN and submit the claim with a GX modifier if it is expected that Medicare will deny payment for a service under the statutory exclusion for purely

[23] CMS. (2024). Chapter 30 - Financial liability protections. In *Medicare Claims Processing Manual*.

cosmetic services. Under those circumstances, an ABN is voluntary and is not required to bill the WISeR Beneficiary for the service that is denied under the cosmetic services exclusion. However, CMS encourages WISeR Providers and WISeR Suppliers to issue an ABN in this situation to inform the WISeR Beneficiary of the likelihood of financial liability.

8.2. Claims Exclusions

The following claim types are excluded from the WISeR prior authorization process and pre-payment medical review described in this guide, unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Medicare Advantage sub-category Indirect Medical Education (IME)-only claims
- Part A and Part B rebilling
- Claims for emergency department services when the claim is submitted with an ET modifier or 045x revenue code (This does not exclude these claims from regular medical review.)

Section 9. Secondary Insurance

This section addresses instances when the WISeR Beneficiary has more than one insurance. In these instances, Medicare must be either the primary or secondary insurance company.

9.1. Medicare as the Primary Insurance

When Medicare is primary and another insurance company is secondary:

- The MAC will suspend claims to request documentation and conduct a review of the ABN when there is no prior authorization request and the claim is submitted with the GA modifier appended.
- The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).[24]

WISeR Providers and WISeR Suppliers who choose to use the prior authorization process to obtain a claim denial should use the following process:

- The requester may submit the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements are not met for the service, a non-affirmative prior authorization decision will be sent to the WISeR Provider or WISeR Supplier and WISeR Beneficiary, advising that Medicare will not pay for the item.
- After the requester receives a non-affirmative decision for the prior authorization request, if the WISeR Provider or WISeR Supplier submits the associated claim to the MAC for payment, it will be denied.

[24] CMS. (2024). Chapter 30 - Financial liability protections. In *Medicare Claims Processing Manual*.

- The WISeR Provider, WISeR Supplier, or WISeR Beneficiary may forward the denied claim to the WISeR Beneficiary's secondary insurance payer as appropriate to determine payment for the service.

When a WISeR Beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The WISeR Provider or WISeR Supplier may need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment.

9.2. Medicare as the Secondary Insurance

When another insurance company is primary and Medicare is secondary:

- The requester submits the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements are met for the item(s), the WISeR Participant will send a provisional affirmative prior authorization decision to the WISeR Provider or WISeR Supplier and to the WISeR Beneficiary, if specifically requested by the WISeR Beneficiary, advising them that Medicare will pay for the service.
- The WISeR Provider or WISeR Supplier submits a claim to the other insurance company.
- If the other insurance company denies the claim, the WISeR Provider, WISeR Supplier, or WISeR Beneficiary can submit a claim to the MAC for payment (listing the UTN on the claim).

Section 10. Claim Appeals

Claims subject to prior authorization or pre-payment medical review requirements under the WISeR Model will follow all current appeals procedures. A prior authorization request that is non-affirmed is not an initial determination on a claim for payment for services provided and, therefore, would not be appealable; however, the requester has an unlimited number of opportunities to resubmit a prior authorization request, provided the claim has not yet been submitted and denied.

A non-affirmation prior authorization decision does not prevent the provider from submitting a claim. Submission of such a claim and the MAC's resulting denial would constitute an initial payment determination, which would make the appeal rights available.

For further information, please consult the Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decision.[25]

[25] CMS. (2023). Chapter 29 - Appeals of claims decisions. In *Medicare Claims Processing Manual*.

Appendices

Appendix A. WISeR Select Items and Services as of March 12, 2026[26]

The following Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes,[27] organized by service category and shown in Tables A1 to A13, are subject to prior authorization or pre-payment medical review under the WISeR Model.

Table A1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)

Code	Code description
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

Table A2. Induced Lesions of Nerve Tracts (NCD 160.1)

Code	Code description
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring

Table A3. Vagus Nerve Stimulation (NCD 160.18)

Code	Code description
64568	Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

Note: Prior authorization and pre-payment medical review for vagus nerve stimulation will only be implemented for the indications specified in Appendix B.

Table A4. Phrenic Nerve Stimulator (NCD 160.19)

Code	Code description
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (list separately in addition to code for primary procedure)

[26] These codes will be maintained for the duration of the WISeR Model and could be subject to change. Any updates would be included in a future version of the WISeR Provider and Supplier Operational Guide.

[27] CPT codes and descriptions only are copyright 2024 American Medical Association (AMA). All rights are reserved, and applicable Federal Acquisition Regulations (FARS)/Defense Federal Acquisition Regulation Supplements (DFARS) clauses apply.

Table A5. Electrical Nerve Stimulators (NCD 160.7)

Code	Code description
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Note: Current Procedural Terminology code 63650 for implanted spinal stimulator is included in CMS' Prior Authorization Program for Certain Hospital Outpatient Department Services. For more information, please visit the Prior Authorization for Certain Hospital Outpatient Department Services webpage.

Table A6. Incontinence Control Devices (NCD 230.10)

Code	Code description
53440	Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance
57288	Placement of a sling made of fascia or synthetic material under the urethra to support it in the correct position to treat urinary stress incontinence

Table A7. Sacral Nerve Stimulation for Urinary Incontinence (NCD 230.18)

Code	Code description
64561[a]	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement), including image guidance, if performed
64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)

Note: Prior authorization for Sacral Nerve Stimulation for Urinary Incontinence will be implemented only for the indications specified in Appendix B.

[a] Please note that trial implantation and replacements billed under Current Procedural Terminology code 64561 do not require prior authorization or pre-payment review under WISeR. During pre-payment review, the billing of a generator implantation code (CPT code 64590) will be used to differentiate between a trial and permanent implantation (billed using CPT code 64561).

Table A8. Diagnosis and Treatment of Impotence (NCD 230.4)

Code	Code description
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multicomponent, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

Table A9. Percutaneous Vertebral Augmentation for Vertebral Compression Fracture (LCD L34228, L38201, L35130)

Code	Code description
22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure)
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)

Table A10. Epidural Steroid Injections for Pain Management (LCD L39015, L39240, L36920)

Code	Code description
62321	Injection(s) of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
62323[a]	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral; with imaging guidance (i.e., fluoroscopy or CT)
64479	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (list separately in addition to code for primary procedure)

Code	Code description
64483	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (list separately in addition to code for primary procedure)

Note: Please reference the associated Local Coverage Determination (LCD) Reference Articles for the selected LCDs for more information about ICD-10 codes that support medical necessity for this service as defined by the Medicare Administrative Contractor.
[a] Please note that CPT code 62323 does not require prior authorization or pre-payment review under WISeR when submitted for indications other than specified in the selected LCDs, including but not limited to implantation of an intrathecal pump for treatment of pain or spasticity.
CT = computed tomography; ICD-10 = International Classification of Diseases and Related Health Programs, 10th Revision.

Table A11. Cervical Fusion (LCD L39741, L39758, and L39793)

Code	Code description
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below c2

Note: Current Procedural Terminology codes 22551 and 22552 for cervical fusion are included in CMS' Prior Authorization Program for Certain Hospital Outpatient Department Services. For more information, please visit the Prior Authorization for Certain Hospital Outpatient Department Services webpage.

Table A12. Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (LCD L38307, L38310, and L38385)

Code	Code description	Date Information (if applicable)
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	
C8007	Open implantation of hypoglossal nerve neurostimulator array and pulse generator, not requiring an insertion of a separate distal respiratory sensor electrode or electrode array	Code available as of April 1, 2026; applicable for services delivered January 1, 2026 or later
C8011	Open implantation of hypoglossal nerve(s) neurostimulator electrode array(s) and receiver, including external power source and all system components	Code available as of April 1, 2026; applicable for services delivered January 1, 2026 or later

Note: As published in the MLN Connects® Newsletter on January 22, 2026, WISeR does not include CPT 64568 billed with ICD-10 code G47.33 (obstructive sleep apnea). Additionally, CMS added new HCPCS codes to the April 2026 Integrated Outpatient Code Editor, effective January 1, 2026, as published in the MLN Connects® Newsletter on February 26, 2026. Providers with questions about billing for HGNS should contact their respective MAC.

Table A13. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (LCD L35041) and Wound Application of CTPs, Lower Extremities (LCD L36690)

WISeR removed HCPCS codes C5271 through C5278 to align with the Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule (90 FR 53748) that went into effect on January 1, 2026.

Code	Code description
15271	Application of skin substitute graft to trunk, arms, and/or legs; total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272	Application of skin substitute graft to trunk, arms, and/or legs; total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15273	Application of skin substitute graft to trunk, arms, and/or legs; total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, and/or legs; total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)

Note: Prior authorization for Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds and Wound Application of Cellular and Tissue Based Products, Lower Extremities will only be implemented for the indications specified in Appendix B.
CTP = Cellular and/or Tissue-Based Products.

Appendix B. ICD-10 Indications for Relevant WISeR Items and Services as of March 12, 2026[28]

Please note that WISeR will align to the coding guidance as defined in the selected National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) (and LCD Reference Articles) for all selected items and services in WISeR.

Table B1. Vagus Nerve Stimulation (VNS) (NCD 160.18)

WISeR removed ICD-10 code G47.33 (obstructive sleep apnea) from the Provider and Supplier Operation Guide in February 2026 to align with CMS guidance issued on January 22, 2026 in its MLN Connects® Newsletter that removed ICD-10 code G47.33 as a covered indication for CPT code 64568 under NCD 160.18.

ICD-10 code	ICD-10 code description
G40.011	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
G40.019	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
G40.111	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.211	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode, depressed severe, without psychotic features
F31.81	Bipolar II disorder
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent, severe without psychotic features
Z00.6	Encounter for examination for normal comparison and control in clinical research program

[28] These codes will be maintained for the duration of the WISeR Model and could be subject to change. Any updates would be included in a future version of the WISeR Provider and Supplier Operational Guide. ICD-10 refers to the International Classification of Diseases and Related Health Problems, 10th Revision.

Table B2. Sacral Nerve Stimulation (NCD 230.18)

ICD-10 code	ICD-10 code description
N39.41	Urge incontinence
N39.42	Incontinence without sensory awareness
N39.46	Mixed incontinence
R33.8	Other retention of urine
R33.9	Retention of urine, unspecified
R35.0	Frequency of micturition
R39.11	Hesitancy of micturition
R39.14	Feeling of incomplete bladder emptying
R39.15	Urgency of urination

Table B3. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (LCD L35041) and Wound Application of CTPs, Lower Extremities (LCD L36690)

ICD-10 code	ICD-10 code description
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E10.621	Type 1 diabetes mellitus with foot ulcer
E11.621	Type 2 diabetes mellitus with foot ulcer
E13.621	Other specified diabetes mellitus with foot ulcer
I83.011	Varicose veins of right lower extremity with ulcer of thigh
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle
I83.014	Varicose veins of right lower extremity with ulcer of heel and midfoot
I83.015	Varicose veins of right lower extremity with ulcer other part of foot
I83.018	Varicose veins of right lower extremity with ulcer other part of lower leg
I83.021	Varicose veins of left lower extremity with ulcer of thigh
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel and midfoot
I83.025	Varicose veins of left lower extremity with ulcer other part of foot
I83.028	Varicose veins of left lower extremity with ulcer other part of lower leg
I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation

ICD-10 code	ICD-10 code description
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I87.011	Postthrombotic syndrome with ulcer of right lower extremity
I87.012	Postthrombotic syndrome with ulcer of left lower extremity
I87.013	Postthrombotic syndrome with ulcer of bilateral lower extremity
I87.031	Postthrombotic syndrome with ulcer and inflammation of right lower extremity
I87.032	Postthrombotic syndrome with ulcer and inflammation of left lower extremity
I87.033	Postthrombotic syndrome with ulcer and inflammation of bilateral lower extremity
I87.311	Chronic venous hypertension (idiopathic) with ulcer of right lower extremity
I87.312	Chronic venous hypertension (idiopathic) with ulcer of left lower extremity
I87.313	Chronic venous hypertension (idiopathic) with ulcer of bilateral lower extremity
I87.331	Chronic venous hypertension (idiopathic) with ulcer and inflammation of right lower extremity
I87.332	Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity
I87.333	Chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity
L97.111	Non-pressure chronic ulcer of right thigh limited to breakdown of skin
L97.112	Non-pressure chronic ulcer of right thigh with fat layer exposed
L97.115	Non-pressure chronic ulcer of right thigh with muscle involvement without evidence of necrosis
L97.116	Non-pressure chronic ulcer of right thigh with bone involvement without evidence of necrosis

ICD-10 code	ICD-10 code description
L97.121	Non-pressure chronic ulcer of left thigh limited to breakdown of skin
L97.122	Non-pressure chronic ulcer of left thigh with fat layer exposed
L97.211	Non-pressure chronic ulcer of right calf limited to breakdown of skin
L97.212	Non-pressure chronic ulcer of right calf with fat layer exposed
L97.215	Non-pressure chronic ulcer of right calf with muscle involvement without evidence of necrosis
L97.216	Non-pressure chronic ulcer of right calf with bone involvement without evidence of necrosis
L97.221	Non-pressure chronic ulcer of left calf limited to breakdown of skin
L97.222	Non-pressure chronic ulcer of left calf with fat layer exposed
L97.311	Non-pressure chronic ulcer of right ankle limited to breakdown of skin
L97.312	Non-pressure chronic ulcer of right ankle with fat layer exposed
L97.315	Non-pressure chronic ulcer of right ankle with muscle involvement without evidence of necrosis
L97.316	Non-pressure chronic ulcer of right ankle with bone involvement without evidence of necrosis
L97.321	Non-pressure chronic ulcer of left ankle limited to breakdown of skin
L97.322	Non-pressure chronic ulcer of left ankle with fat layer exposed
L97.411	Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
L97.412	Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
L97.415	Non-pressure chronic ulcer of right heel and midfoot with muscle involvement without evidence of necrosis
L97.416	Non-pressure chronic ulcer of right heel and midfoot with bone involvement without evidence of necrosis
L97.421	Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin
L97.422	Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed
L97.511	Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin
L97.512	Non-pressure chronic ulcer of other part of right foot with fat layer exposed
L97.515	Non-pressure chronic ulcer of other part of right foot with muscle involvement without evidence of necrosis
L97.516	Non-pressure chronic ulcer of other part of right foot with bone involvement without evidence of necrosis
L97.521	Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin
L97.522	Non-pressure chronic ulcer of other part of left foot with fat layer exposed

ICD-10 code	ICD-10 code description
L97.525	Non-pressure chronic ulcer of other part of left foot with muscle involvement without evidence of necrosis
L97.526	Non-pressure chronic ulcer of other part of left foot with bone involvement without evidence of necrosis
L97.811	Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin
L97.812	Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed
L97.821	Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin
L97.822	Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed
L97.825	Non-pressure chronic ulcer of other part of left lower leg with muscle involvement without evidence of necrosis
L97.826	Non-pressure chronic ulcer of other part of left lower leg with bone involvement without evidence of necrosis

Appendix C. WISeR Associated Codes List as of March 12, 2026

Associated codes are related to a WISeR item or service. The associated codes in Appendix C are not designed to be treated as stand-alone services and will not require separate prior authorization or pre-payment review. Claims for associated codes will be paid (assuming all existing requirements relevant to the associated codes are met) if a primary code for a WISeR Select Item or Service is affirmed during prior authorization or approved during pre-payment review. Claims for associated codes will be denied and/or payments for associated codes will be recouped if a primary code for a WISeR Select Item or Service has a non-affirmed prior authorization or is denied during pre-payment review.

Notes:

- Appendix C was updated in February 2026 to reflect changes to select HCPCS/CPT codes in Table C13, Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (LCD L35041) and Wound Application of CTPs, Lower Extremities (LCD L36690)
- These codes will be maintained for the duration of the WISeR Model and could be subject to change. Any updates would be included in a future version of the WISeR Provider and Supplier Operational Guide.

Table C1. Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)

Associated code	Associated code description
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29880	Arthroscopy, knee, surgical; with meniscectomy (medial *and* lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial *or* lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
64447	Injection(s), anesthetic agent(s), and/or steroid; femoral nerve, including imaging guidance, when performed

Table C2. Induced Lesions of Nerve Tracts (NCD 160.1)

Associated code	Associated code description
61790	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (e.g., alcohol, thermal, electrical, radiofrequency); gasserian ganglion
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
70450	Computed tomography (CT) scan, head or brain; without contrast material
76000	Fluoroscopy, 60 minutes or less
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
00222	Anesthesia for intracranial procedures; electrocoagulation of intercranial nerve
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position

Table C3. Vagus Nerve Stimulation (NCD 160.18)

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
64568	Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller

Table C4. Phrenic Nerve Stimulators (NCD 160.19)

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (list separately in addition to code for primary procedure)
70360	Radiologic examination of the pharynx and soft tissues of the neck, including lateral and anteroposterior views
71045	Radiologic examination of the chest, single view
71046	X-ray exam of chest; two views
99100	Anesthesia services provided to a patient of extreme age, younger than 1 year or older than 70 years (list separately in addition to the primary anesthesia procedure)
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intraservice time
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1769	Guide wire
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
C1887	Catheter, guiding (may include infusion/perfusion capability)
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away

Associated code	Associated code description
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser

Table C5. Electrical Nerve Stimulators (NCD 160.7)

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
00620	Anesthesia for procedures on thoracic spine and cord; not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, and epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
72020	X-ray exam of spine, single view
95861	Needle electromyography; two extremities with or without related paraspinal areas
95870	Needle electromyography; limited study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve–supplied muscles, or sphincter
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Placement of skin electrodes and measurement of central motor stimulation in arms and legs
95955	Measurement of brain wave activity (EEG) outside the brain during surgery
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

Associated code	Associated code description
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient (attention directed exclusively to one patient), each 15 minutes (list in addition to primary procedure)

Note: EEG = electroencephalogram.

Table C6. Incontinence Control Devices (NCD 230.10)

Associated code	Associated code description
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified
00860	Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified
00910	Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified
51600	Injection procedure for x-ray imaging of bladder during voiding
53440	Sling operation for correction of male urinary incontinence (e.g., fascia or synthetic)
53444	Insertion of tandem cuff (dual cuff)
53445	Insertion of inflatable urethra or bladder neck sphincter
53449	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff

Associated code	Associated code description
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume
57288	Placement of a sling made of fascia or synthetic material under the urethra to support it in the correct position to treat urinary stress incontinence
74420	Urography, retrograde, with or without KUB
74430	Cystography, minimum of three views, radiological supervision and interpretation
76000	Fluoroscopy, 60 minutes or less
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70
C1771	Repair device, urinary, incontinence, with sling graft
C1781	Mesh (implantable)
C1813	Prosthesis, penile, inflatable
C1815	Prosthesis, urinary sphincter (implantable)
C1889	Implantable/insertable device for device-intensive procedure, not otherwise classified

Note: KUB = kidney, ureter, and bladder.

Table C7. Sacral Nerve Stimulators for Urinary Incontinence (NCD 230.18)

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
00630	Anesthesia for procedures in the lumbar region; not otherwise specified
64561	Insertion of sacral nerve neurostimulator electrode array
64581	Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
72220	X-ray exam, sacrum and coccyx, minimum of two views

Associated code	Associated code description
76000	Fluoroscopy, 60 minutes or less
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
99100	Anesthesia services provided to a patient of extreme age, younger than 1 year or older than 70 years (list separately in addition to the primary anesthesia procedure)
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)

Table C8. Diagnosis and Treatment of Impotence (NCD 230.4)

Associated code	Associated code description
00920	Anesthesia for procedures on male genitalia (including open urethral procedures); not otherwise specified
00938	Anesthesia for procedures on male genitalia (including open urethral procedures); insertion of penile prosthesis (perineal approach)
54360	Plastic operation on penis to correct angulation
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multicomponent inflatable penile implant
54406	Removal of all components of a multicomponent, inflatable penile prosthesis without replacement of prosthesis
C1813	Prosthesis, penile, inflatable
C1889	Implantable/insertable device for device-intensive procedure, not otherwise classified
C2622	Prosthesis, penile, non-inflatable

Table C9. Percutaneous Vertebral Augmentation for Vertebral Compression Fracture (LCD L34228, L38201, L35130)

Associated code	Associated code description
01941	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (e.g., kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic
01942	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (e.g., kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar sacral
22510	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512	Percutaneous vertebroplasty (bone biopsy included when performed), one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure)
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), one vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

Associated code	Associated code description
99153	Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intraservice time
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1889	Implantable/insertable device for device-intensive procedure; not otherwise classified

Table C10. Epidural Steroid Injections for Pain Management (LCD L39015, L39240, L36920)

Associated code	Associated code description
01937	Anesthesia for percutaneous image-guided injection, drainage, or aspiration procedures on the spine or spinal cord; cervical or thoracic
62321	Injection(s) of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or computed tomography [CT])
62323	Injection(s) of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral; with imaging guidance (i.e., fluoroscopy or CT)
64479	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (list separately in addition to code for primary procedure)

Associated code	Associated code description
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

Table C11. Cervical Fusion (LCD L39741, L39758, L39793)

Associated code	Associated code description
20930	Placement of fragmented bone graft or material to spine to promote bone growth
20931	Graft of donor bone to spine
20936	Harvest of bone from same spine incision for graft
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below c2
22845	Anterior instrumentation; two to three vertebral segments (list separately in addition to code for primary procedure)
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (list separately in addition to code for primary procedure)
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (list separately in addition to code for primary procedure)
72020	X-ray exam of spine, single view

Associated code	Associated code description
72040	X-ray exam of upper (neck) spine, two to three views
76000	Fluoroscopy, 60 minutes or less
95861	Needle electromyography; two extremities with or without related paraspinal areas
95937	Neuromuscular junction test
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
95939	Placement of skin electrodes and measurement of central motor stimulation in arms and legs
95955	Measurement of brain wave activity (EEG) outside the brain during surgery
00600	Anesthesia for procedures on cervical spine and cord; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1762	Connective tissue, human (includes fascia lata)
C1889	Implantable/insertable device for device-intensive procedure, not otherwise classified
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient), each 15 minutes (list in addition to primary procedure)

Note: EEG = electroencephalogram.

Table C12. Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (LCD L38307, L38310, L38385)

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
42975	Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing; flexible, diagnostic
64568	Open implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator

Associated code	Associated code description
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array
70360	Radiologic examination of the pharynx and soft tissues of the neck, including lateral and anteroposterior views
71045	Radiologic examination of the chest, single view
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator

Table C13. Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (LCD L35041) and Wound Application of CTPs, Lower Extremities (LCD L36690)

WISeR removed CPT codes C5271 through C5278 to align with the Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule (90 FR 53748) that went into effect on January 1, 2026.

Associated code	Associated code description
00300	Anesthesia for procedures on the integumentary system, muscles, and nerves of the head, scalp, and neck
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01480	Anesthesia for other procedure on lower leg, ankle, and foot bones
15002	Preparation of skin graft site of trunk, arms, or legs; 100.0 sq cm or 1% body area for infants and children, or less
15003	Preparation of skin graft site of trunk, arms, or legs; each additional 100.0 sq cm or 1% body area for infants and children, or less
15004	Preparation of skin graft site of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes; 100.0 sq cm or 1% body area for infants and children, or less
15005	Preparation of skin graft site of face, scalp, eyelids, mouth, neck, ears, around eyes, genitals, hands, feet, fingers, or toes; each additional 100.0 sq cm or 1% body area for infants and children, or less
15271	Application of skin substitute graft to wound of trunk, arms, or legs; 25.0 sq cm or less of wound, 100.0 sq cm or less
15272	Application of skin substitute graft to trunk, arms, or legs; total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)

Associated code	Associated code description
15273	Application of skin substitute graft to trunk, arms, or legs; total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Application of skin substitute graft to trunk, arms, or legs; total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area or 1% of body area of infants and children
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)
A2001	InnovaMatrix AC, per square centimeter
A2002	Mirragen Advanced Wound Matrix, per square centimeter
A2005	Microlyte Matrix, per square centimeter
A2006	NovoSorb SynPath dermal matrix, per square centimeter
A2007	Restrata, per square centimeter
A2008	TheraGenesis, per square centimeter
A2009	Symphony, per square centimeter
A2010	APIS, per square centimeter
A2011	Supra SDRM, per square centimeter
A2012	SUPRATHEL, per square centimeter
A2013	InnovaMatrix FS, per square centimeter

Associated code	Associated code description
A2015	Phoenix wound matrix, per square centimeter
A2016	PermeaDerm B, per square centimeter
A2018	PermeaDerm C, per square centimeter
A2019	Kerecis Omega3 MariGen shield, per square centimeter
A2021	NeoMatrix, per square centimeter
A2022	InnovaBurn or InnovaMatrix XL, per square centimeter
A2024	Resolve matrix, per square centimeter
A2027	MatriDerm, per square centimeter
A4100	Skin substitute, Federal Drug Administration cleared as a device; not otherwise specified
Q4100	Skin substitute; not otherwise specified
Q4101	Apligraf, per square centimeter
Q4102	Oasis wound matrix, per square centimeter
Q4103	Oasis burn matrix, per square centimeter
Q4104	Integra Bilayer Matrix Wound Dressing (BMWD), per square centimeter
Q4105	Integra Dermal Regeneration Template (DRT) or Integra Omnigraft Dermal Regeneration Matrix, per square centimeter
Q4106	Dermagraft, per square centimeter
Q4107	GraftJacket, per square centimeter
Q4108	Integra Wound Matrix, per square centimeter
Q4110	PriMatrix, per square centimeter
Q4111	GammaGraft, per square centimeter
Q4115	AlloSkin, per square centimeter
Q4116	AlloDerm, per square centimeter
Q4117	Hyalomatrix, per square centimeter
Q4121	TheraSkin, per square centimeter
Q4122	Dermacell, Dermacell AWN or Dermacell AWN Porous, per square centimeter
Q4123	AlloSkin RT, per square centimeter
Q4124	Oasis Ultra Tri-Layer Wound Matrix, per square centimeter
Q4125	ArthroFlex, per square centimeter
Q4126	MemoDerm, DermaSpan, TranzGraft, or Integuply, per square centimeter

Associated code	Associated code description
Q4127	Talymed, per square centimeter
Q4128	FlexHD or AlloPatch HD, per square centimeter
Q4130	Strattice TM, per square centimeter
Q4132	GRAFIX CORE and Grafix PL CORE, per square centimeter
Q4133	GRAFIX PRIME, GRAFIX PL PRIME, STRAVIX, and STRAVIX PL, per square centimeter
Q4134	hMatrix, per square centimeter
Q4135	mediSKIN, per square centimeter
Q4136	EZ-Derm, per square centimeter
Q4137	AmnioExcel, AmnioExcel Plus, or Biodexcel, per square centimeter
Q4138	BioDFence DryFlex, per square centimeter
Q4140	BioDFence, per square centimeter
Q4141	AlloSkin AC, per square centimeter
Q4142	XCM Biologic Tissue Matrix, per square centimeter
Q4143	Repriza, per square centimeter
Q4146	Tensix, per square centimeter
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per square centimeter
Q4148	Neox CORD 1K, Neox CORD RT, or Clarix Cord 1K, per square centimeter
Q4150	AlloWrap DS or Dry, per square centimeter
Q4151	AmnioBand or Guardian, per square centimeter
Q4152	DermaPure, per square centimeter
Q4153	Dermavest and Plurivest, per square centimeter
Q4154	Biovance, per square centimeter
Q4156	Neox 100 or Clarix 100, per square centimeter
Q4157	REVITALON, per square centimeter
Q4158	Kerecis Omega3, per square centimeter
Q4159	Affinity, per square centimeter
Q4160	NuShield, per square centimeter
Q4161	bio-ConneKt Wound Matrix, per square centimeter
Q4163	Woundex, BioSkin, per square centimeter

Associated code	Associated code description
Q4164	Helicoll, per square centimeter
Q4165	Keramatrix or Kerasorb, per square centimeter
Q4166	Cytal, per square centimeter
Q4167	TruSkin, per square centimeter
Q4169	Artacent Wound, per square centimeter
Q4170	Cygnus, per square centimeter
Q4173	PalinGen or PalinGen XPlus, per square centimeter
Q4175	MiroDerm, per square centimeter
Q4176	NeoPatch or Therion, per square centimeter
Q4178	FlowerAmnioPatch, per square centimeter
Q4179	FlowerDerm, per square centimeter
Q4180	Revita, per square centimeter
Q4181	Amnio wound, per square centimeter
Q4182	TransCyte, per square centimeter
Q4183	Surgigraft, per square centimeter
Q4184	Cellesta or Cellesta Duo, per square centimeter
Q4186	EPIFIX, per square centimeter
Q4187	EPICORD, per square centimeter
Q4188	AmnioArmor, per square centimeter
Q4190	Artacent AC, per square centimeter
Q4191	Restorigin, per square centimeter
Q4193	Coll-e-Derm, per square centimeter
Q4194	Novachor, per square centimeter
Q4195	PuraPly, per square centimeter
Q4196	PuraPly AM, per square centimeter
Q4197	PuraPly XT, per square centimeter
Q4198	Genesis Amniotic Membrane, per square centimeter
Q4199	CYGNUS Matrix, per square centimeter
Q4200	SkinTE, per square centimeter
Q4201	Matrion, per square centimeter

Associated code	Associated code description
Q4203	Derma-Gide, per square centimeter
Q4204	XWRAP, per square centimeter
Q4205	Membrane graft or membrane wrap, per square centimeter
Q4208	Novafix, per square centimeter
Q4209	SurGraft, per square centimeter
Q4211	Amnion bio or AxoBioMembrane, per square centimeter
Q4214	Cellesta Cord, per square centimeter
Q4216	Artacent Cord, per square centimeter
Q4217	WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound XPlus, per square centimeter
Q4218	SurgiCORD, per square centimeter
Q4219	SurgiGRAFT-DUAL, per square centimeter
Q4220	BellaCell HD or SureDerm, per square centimeter
Q4221	AmnioWrap2, per square centimeter
Q4222	ProgenaMatrix, per square centimeter
Q4225	AmnioBand, per square centimeter
Q4226	MyOwn Skin, includes harvesting and preparation procedures, per square centimeter
Q4227	AmnioCore, per square centimeter
Q4229	Cogenex Amniotic Membrane, per square centimeter
Q4232	Corplex, per square centimeter
Q4234	Xcellerate, per square centimeter
Q4235	AmnioRepair or AltiPly, per square centimeter
Q4236	carePATCH, per square centimeter
Q4237	Cryo-Cord, per square centimeter
Q4238	Derm-Maxx, per square centimeter
Q4239	Amnio-Maxx or Amnio-Maxx lite, per square centimeter
Q4247	AmnioText Patch, per square centimeter
Q4248	Dermacyte Amniotic Membrane Allograft, per square centimeter
Q4249	AmniPly, for topical use only, per square centimeter
Q4250	AmnioAMP-MP, per square centimeter

Associated code	Associated code description
Q4251	VIM, per square centimeter
Q4252	Vendaje, per square centimeter
Q4253	Zenith Amniotic Membrane, per square centimeter
Q4254	Novafix DL, per square centimeter
Q4255	REGUaRD, for topical use only, per square centimeter
Q4256	MLG-Complete, per square centimeter
Q4257	Relese, per square centimeter
Q4258	Enverse, per square centimeter
Q4259	Celera Dual Layer or Celera Dual Membrane, per square centimeter
Q4260	Signature APatch, per square centimeter
Q4261	TAG, per square centimeter
Q4262	Dual Layer Impax Membrane, per square centimeter
Q4263	SurGraft TL, per square centimeter
Q4264	Cocoon membrane, per square centimeter
Q4265	NeoStim TL, per square centimeter
Q4266	NeoStim Membrane, per square centimeter
Q4267	NeoStim DL, per square centimeter
Q4268	SurGraft FT, per square centimeter
Q4269	SurGraft XT, per square centimeter
Q4270	Complete SL, per square centimeter
Q4271	Complete FT, per square centimeter
Q4272	Esano A, per square centimeter
Q4273	Esano AAA, per square centimeter
Q4274	Esano AC, per square centimeter
Q4275	Esano ACA, per square centimeter
Q4276	Orion, per square centimeter
Q4278	EPIEFFECT, per square centimeter
Q4279	Vendaje AC, per sq cm N Low
Q4280	Xcell Amnio Matrix, per square centimeter
Q4281	Barrera SL or Barrera DL, per square centimeter

Associated code	Associated code description
Q4282	CYGNUS Dual, per square centimeter
Q4283	Biovance Tri-Layer or Biovance 3L, per square centimeter
Q4284	DermaBind SL, per square centimeter
Q4285	NuDYN DL or NuDYN DL MESH, per square centimeter
Q4286	NuDYN SL or NuDYN SLW, per square centimeter
Q4287	DermaBind DL, per sq cm N Low
Q4288	DermaBind CH, per sq cm N Low
Q4289	RevoShield+ Amnio, per sq cm N Low
Q4290	Membrane Wrap Hydro per sq cm N Low
Q4291	Lamellas XT, per sq cm N Low
Q4292	Lamellas, per sq cm N Low
Q4293	Acesso DL, per sq cm N Low
Q4294	Amnio quad-core, per sq cm
Q4295	Amnio tri-core, per sq cm N Low
Q4296	Rebound matrix, per sq cm N Low
Q4297	Emerge matrix, per sq cm N Low
Q4298	Amnicore pro, per sq cm N Low
Q4299	Amnicore pro+, per sq cm N Low
Q4300	Acesso TL, per sq cm N Low
Q4301	Activate Matrix, per sq cm N Low
Q4302	Complete ACA, per sq cm N Low
Q4303	Complete AA, per sq cm N Low
Q4304	Grafix Plus, per sq cm N
Q4305	American Amnion AC Tri-Layer per sq cm
Q4306	American Amnion AC per sq cm
Q4307	American Amnion, per sq cm
Q4308	Sanopellis, per sq cm
Q4309	VIA Matrix, per sq cm
Q4311	Acesso, per square centimeter
Q4312	Acesso AC, per square centimeter

Associated code	Associated code description
Q4313	DermaBind FM, per square centimeter
Q4314	Reeva FT, per square centimeter
Q4315	RegeneLink Amniotic Membrane Allograft, per square centimeter
Q4316	AmchoPlast, per square centimeter
Q4317	VitoGraft, per square centimeter
Q4318	E-Graft, per square centimeter
Q4319	SanoGraft, per square centimeter
Q4320	PelloGraft, per square centimeter
Q4321	RenoGraft, per square centimeter
Q4322	caregraFT, per square centimeter
Q4323	alloPLY, per square centimeter
Q4324	AmnioTX, per square centimeter
Q4325	ACApatch, per square centimeter
Q4326	WoundPlus, per square centimeter
Q4327	DuoAmnion, per square centimeter
Q4328	MOST, per square centimeter
Q4329	Singlay, per square centimeter
Q4330	TOTAL, per square centimeter
Q4331	Axolotl Graft, per square centimeter
Q4332	Axolotl DualGraft, per square centimeter
Q4333	ArdeoGraft, per square centimeter
Q4334	Amnioplast 1, per square centimeter
Q4335	Amnioplast 2, per square centimeter
Q4336	Artacent C, per square centimeter
Q4337	Artacent Trident, per square centimeter
Q4338	Artacent Velos, per square centimeter
Q4339	Artacent VeriClen, per square centimeter
Q4340	SimpliGraft, per square centimeter
Q4341	Simplimax, per square centimeter
Q4342	Theramend, per square centimeter

Associated code	Associated code description
Q4343	Dermacyte AC Matrix Amniotic Membrane Allograft, per square centimeter
Q4344	Tri-Membrane Wrap, per square centimeter
Q4345	Matrix HD Allograft Dermis, per square centimeter
Q4346	Shelter DM Matrix, per square centimeter
Q4347	Rampart DL Matrix, per square centimeter
Q4348	Sentry SL Matrix, per square centimeter
Q4349	Mantle DL Matrix, per square centimeter
Q4350	Palisade DM Matrix, per square centimeter
Q4351	Enclose TL Matrix, per square centimeter
Q4352	Overlay SL Matrix, per square centimeter
Q4353	Xceed TL Matrix, per square centimeter
Q4354	PalinGen Dual Layer sq cm
Q4355	Abiomend Xplus, Abiomend Xplus Hydromembrane per sq cm
Q4356	Abiomend, Abiomend Hydromembrane per sq cm
Q4357	XWRAP Plus, per sq cm
Q4358	XWRAP Dual, per sq cm
Q4359	Choriply, per sq cm
Q4360	AmchoPlast FD per sq cm
Q4361	EPIXPRESS, per sq cm
Q4362	CYGNUS Disk, per sq cm
Q4363	Amnio Burgeon Membrane and Hydromembrane, per sq cm
Q4364	Amnio Burgeon Xplus Membrane and Xplus Hydromembrane, per sq cm
Q4365	Amnio Burgeon Dual-Layer Membrane, per sq cm
Q4366	Dual Layer Amnio Burgeon X-Membrane, per sq cm
Q4367	AmnioCore SL, per sq cm
Q4368	AmchoThick, per sq cm
Q4369	AmnioPlast 3, per sq cm
Q4370	AeroGuard per sq cm
Q4371	NeoGuard per sq cm
Q4372	AmchoPlast EXCEL, per sq cm

Associated code	Associated code description
Q4373	Membrane Wrap-Lite, per sq cm
Q4375	DuoGRAFT AC, per sq cm
Q4376	Duograft AA, per sq cm
Q4377	TriGRAFT FT, per sq cm
Q4378	Renew FT Matrix, per sq cm
Q4379	AmnioDefend FT, per sq cm
Q4380	AdvoGraft One, per sq cm
Q4382	AdvoGraft Dual, per sq cm

Appendix D. Acronym Glossary

Acronym	Definition
ABN	Advanced Beneficiary Notice of Non-Coverage
ACC	American College of Cardiology
ADR	Additional documentation request
AHA	American Heart Association
AHI	Apnea-hypopnea index
ASC	Ambulatory Surgical Center
ASV	Adaptive servo-ventilation
BiPAP	Bilevel positive airway pressure
BMI	Body mass index
CCN	CMS Certification Number
CED	Coverage with Evidence Development
CFR	Code of Federal Regulations
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPAP	Continuous positive airway pressure
CPT	Current Procedural Terminology
CRT	Cardiac resynchronization therapy
CTPs	Cellular and/or Tissue-Based Products
CSA	Central sleep apnea
esMD	Electronic Submission of Medical Documentation
FISS	Fiscal Intermediary Shared System
GDMT	Guideline-directed medical therapy
HCPCS	Healthcare Common Procedure Coding System
HF	Heart failure
HGNS	Hypoglossal nerve stimulation
ICD	Implantable cardioverter-defibrillator
ICD-10	International Classification of Diseases and Related Health Problems, 10th Revision
LCD	Local Coverage Determination
LSS	Lumbar Spinal Stenosis
LVEF	Left ventricular ejection fraction
MAC	Medicare Administrative Contractor
MDE	Major depressive episode
NCD	National Coverage Determination
NPI	National Provider Identifier
NYHA	New York Heart Association
OPD	Outpatient Department
OPPS	Outpatient Prospective Payment System
PILD	Percutaneous image-guided lumbar decompression
POS	Place of Service
PTAN	Provider Transaction Access Number
PVA	Percutaneous Vertebral Augmentation
REF	Prior authorization reference

Acronym	Definition
SOC	Standard of care
TIA	Transient ischemic attack
UTN	Unique Tracking Number
VCF	Vertebral compression fracture
VNS	Vagus nerve stimulation
WISeR Model	Wasteful and Inappropriate Service Reduction Model