



**Centers for Medicare & Medicaid Services
Center for Medicare and
Medicaid Innovation (CMMI)**

WISeR Participant Guide

*Prior Authorization and Pre-Payment Medical Review Processes
and Payment Methodology*

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About This Guide

The purpose of the Wasteful and Inappropriate Service Reduction (WISeR) Participant Guide is to provide additional guidance to WISeR Participants regarding their roles and responsibilities implementing and operating the WISeR prior authorization and pre-payment medical review processes. This guide also provides additional details on the WISeR Payment methodology, including the reconciliation process and the calculation of payments for non-affirmed and denied pre-payment medical reviews.

This guide is intended to serve as a practical resource to support operations and does not modify the requirements outlined in the WISeR Participation Agreement or Business Associate Agreements (BAA) between Centers for Medicare & Medicaid Services (CMS) and WISeR Participants. In the event of any conflict between the provisions of this WISeR Participant Guide and the provisions of the WISeR Participation Agreement or WISeR BAA, the terms of the Participation Agreement and BAA will take precedence. Please note that the terms used in this WISeR Participant Guide have the same meaning as the terms defined in the Participation Agreement between CMS and the WISeR Participants.

1 WISeR Prior Authorization and Pre-Payment Medical Review

1.1 Model Overview

The Center for Medicare and Medicaid Innovation was established to test new payment and service delivery models that reduce Medicare and Medicaid costs while maintaining or improving the quality of care. Original Medicare's fee-for-service (FFS) structure often leads to unnecessary treatments and increases the risk of waste, fraud, and abuse. Medicare Advantage plans and other payers have shown success in reducing these issues by using advanced technologies, such as AI and machine learning, especially in prior authorization and utilization management. The Wasteful and Inappropriate Service Reduction (WISeR) Model aims to apply similar tools in Medicare FFS by working with organizations skilled in these technologies to improve the efficiency and accuracy of service reviews. By focusing on services vulnerable to fraud and waste, the model seeks to decrease clinically unsupported care and better protect beneficiaries while ensuring continued access to appropriate services.

The WISeR Model will begin on January 1, 2026, and run for two 3-year agreement periods, until December 31, 2031. Participants in the model will apply their technology solutions and clinical expertise to enhance the prior authorization and pre-payment medical processes and will coordinate with the Medicare Administrative Contractor (MAC) for the region they are assigned to securely exchange data.

The scope of WISeR will include four MACs and six states within those MAC jurisdictions, also known as WISeR jurisdictions:

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

Each WISeR Participant is assigned to one of these states to implement WISeR. Medicare FFS-enrolled providers and suppliers located in WISeR jurisdictions, that furnish Select Items and Services to WISeR Beneficiaries (referred to as WISeR Providers and WISeR Suppliers), will have the option to submit prior authorization requests for these Select Items and Services. WISeR Providers and WISeR Suppliers that choose not to request prior authorization will have their claims suspended by the MAC prior to payment so that the WISeR Participant can perform pre-payment medical review.

Please note that WISeR does not make changes to existing Medicare FFS coverage, payment, and appeals policies.

1.2 WISeR Participant and the MAC

Under the WISeR Model, WISeR Participants will need to interface with their assigned MACs to implement and manage data flows to support the prior authorization and pre-payment medical review processes.

1.2.1 Joint Operating Agreement

As part of model implementation, the WISeR Participant will need to ensure smooth and frequent communications and data exchanges with the MAC. To clarify and document how these exchanges should happen, the WISeR Participant will enter into a Joint Operating Agreement (JOA) with its designated MAC. The JOA outlines the roles and responsibilities of both the WISeR Participant and the MAC. The purpose of the JOA is to ensure efficient communication processes for the routing of prior authorization requests.

The JOA is intended to be a living document, providing a flexible framework that may be revised as needed. It serves as a high-level outline of principles, approaches, and processes used to create, implement, and maintain effective working relationships, communications, and information flows between the parties. The JOA does not create legal rights, obligations, or affirmative duties for either party or third parties. All time frames included will be mutually agreed upon, unless otherwise governed by law or contract terms with the Centers for Medicare & Medicaid Services (CMS).

Key objectives of the JOA include:

- Familiarize WISeR/MAC management and staff with the MAC and WISeR activities that require mutual support, define areas where joint cooperation is critical, define information sharing strategies and opportunities, and share the final operating plan.
- Promote the strategic benefits of prior authorization for both the MAC and the WISeR Participant.
- Build mutually agreeable strategies to gain acceptance for this change in CMS' approach to prior authorization for Select Items and Services and the upcoming changes associated with its implementation.
- Clearly define and outline the responsibilities of each party and respective responsibilities to the other party.
- Establish methods and processes that actively encourage communications and information flows for the performance of both the MAC and the WISeR Participant.
- Provide processes to jointly resolve issues.

1.2.2 Unique Tracking Numbers

Medicare uses shared systems and mainframe batch jobs to process claims. For each prior authorization request, a Unique Tracking Number (UTN) must be generated by the Medicare claims processing system. This occurs after the MAC enters the initial prior authorization request into the system.

If WISeR Providers and WISeR Suppliers send prior authorization requests directly to the WISeR Participant, the WISeR Participant must notify the MAC and share relevant prior authorization

request data with the MAC. This allows the MAC to initiate a system request to create a UTN. Please note, due to batch cycling, it may take 24–36 hours from the time of the request for the MAC to create a UTN. Once the UTN is created, the MAC will share it with the WISeR Participant, who is then responsible for sending the UTN to the requesting WISeR Provider and/or WISeR Supplier.

UTNs must be tracked and matched to the corresponding prior authorization request using identifying details such as patient name, date of birth, and requesting National Provider Identifier (NPI). After the WISeR Participant makes a prior authorization request determination, the participant will need to transmit the determination, UTN, and other relevant data elements to the MAC through the Electronic Submission of Medical Documentation (esMD) system.

1.3 Communication With Medicare Information Technology (IT) Systems and Data Sharing

1.3.1 Data Security and Privacy Standards

WISeR Participants are responsible for protecting sensitive health information (PHI) while carrying out their model duties. They must follow the Health Insurance Portability and Accountability Act (HIPAA) regulations, the WISeR BAA, and all relevant state and federal laws. Any IT systems or platforms used to connect with Medicare systems must meet federal security standards. These standards include compliance with the Federal Information Security Modernization Act (FISMA)¹ framework, CMS Acceptable Risk Standards,² and the CMS Information Systems Security & Privacy Policy.³ Additionally, WISeR Participants should follow procedures outlined in the CMS Risk Management Handbook⁴ and CMS Business Partners Systems Security Manual⁵ to ensure ongoing security and privacy.

1.3.2 Communication and Connectivity With esMD

Connectivity between WISeR Participants, MACs, and CMS systems is essential for this model to operate. In addition to ensuring compliance with all data and security provisions itemized in the previous section and in the Participation Agreement, CMS expects that WISeR Participants will ensure IT connections are tested prior to use in production. In particular, for the model to operate successfully, WISeR Participants must ensure that they have established secure and verifiable connections with esMD, a Medicare system through which MACs send and receive

¹ CMS. (2023). *Federal Information Security Modernization Act (FISMA)*. <https://security.cms.gov/learn/federal-information-security-modernization-act-fisma>

² CMS. (2022). *CMS Acceptable Risk Safeguards (ARS)*. <https://security.cms.gov/policy-guidance/cms-acceptable-risk-safeguards-ars>

³ CMS. (2024). *CMS Information Systems Security & Privacy Policy (IS2P2)*. <https://security.cms.gov/policy-guidance/cms-information-systems-security-privacy-policy-is2p2>

⁴ CMS. (2023). *CMS guidance for security and privacy policies*. <https://security.cms.gov/learn/cms-security-and-privacy-handbooks#risk-management-handbook-rmh-chapters>

⁵ CMS. (2022). *Centers for Medicare & Medicaid Services business partners systems security manual*. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/117_systems_security.pdf

prior authorization requests and decisions. WISeR Participants will need to onboard to esMD as Review Contractors.⁶

1.4 Pathways to Coverage Determination Under WISeR

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

1. Submitting a prior authorization request to receive a determination prior to administering Select Items and Services, described in Section 1.5
2. Furnishing Select Items and Services immediately and waiting for the determination through pre-payment review, as described in Section 1.9

Please see [Appendix A](#) for a visual display of the prior authorization and pre-payment medical review workflow.

1.5 WISeR Participant Receives Prior Authorization Request

WISeR Providers and WISeR Suppliers have several options for submitting prior authorization requests to the MACs (see Table 1). WISeR Providers and WISeR Suppliers may submit prior authorization requests, including resubmissions, for Select Items and Services to their MAC through fax, mail, esMD, or the MAC electronic portal(s). MACs will send all requests they receive for prior authorization to the WISeR Participant through the esMD system regardless of how the MAC receives the request initially. MACs will note in the esMD transmission to the WISeR Participant how the request was submitted to them.

Additionally, WISeR Participants may accept prior authorization requests directly from WISeR Providers and WISeR Suppliers and must offer fax, mail, esMD, and portal submission options. WISeR Participants must have the capability to send the prior authorization determinations back to the WISeR Provider or WISeR Supplier using the same method the request was originally submitted.

Table 1. Prior authorization receipt and response methods

Prior authorization submission method	WISeR Participant receipt methods	WISeR Participant response methods
Request sent to the WISeR Participant through the MAC	Electronic Submission of Medical Documentation (esMD)	Fax, mail, esMD, WISeR Participant portal
Request sent directly to the WISeR Participant by the WISeR Provider or WISeR Supplier	Fax, mail, esMD, WISeR Participant portal	Fax, mail, esMD, WISeR Participant portal

⁶ Guidance on esMD enrollment may be found in esMD Role Request Quick Reference Guide for AR2023.01.0 Release at <https://www.cms.gov/files/document/esmd-role-request-quick-reference-guide.pdf>.

The WISeR Participant will also establish a procedure to accept and expedite prior authorization requests when delays in review and response could jeopardize the life or health of the beneficiary, as described in Section 1.7.6.

1.6 WISeR Participant Processes Prior Authorization

Once a prior authorization request is received, the WISeR Participant must first verify that the request meets the minimum criteria for processing. This includes, but is not limited to:

- The request is for a Select Item or Service in Appendix A of the WISeR Provider and Supplier Operational Guide, available in the “Additional Information” section of the model website (<https://www.cms.gov/priorities/innovation/innovation-models/wiser>).
- The request is submitted by the corresponding MAC or a WISeR Provider or WISeR Supplier within the WISeR Participant’s WISeR jurisdiction and includes the physician/practitioner or facility billing information. The WISeR Participant will confirm WISeR Provider and WISeR Supplier eligibility using a data file shared regularly by CMS.
- The WISeR Select Item or Service will be furnished to an individual who is a WISeR Beneficiary, as defined in Section 4.1 of the WISeR Participation Agreement. The WISeR Participant will confirm that the request includes a valid WISeR Beneficiary name and Medicare Beneficiary Identifier (MBI) using the HIPAA Eligibility Transaction System (HETS)⁷ or another approved method.⁸ Note: Participants may confirm the beneficiary name using only MBI, last name, and date of birth.⁹

Once a request is determined to be qualified and appropriate for review, the WISeR Participant should use enhanced technology and WISeR Clinicians and Clinical Reviewers to process the prior authorization request, including resubmissions, to ensure that the request meets the following criteria:

- The request includes all documentation necessary to show that the Select Items and Services meet applicable Medicare coverage criteria, including coding and payment rules in Chapter IV of Title 42 or in Title XVIII of the Social Security Act.
- The prior authorization request is submitted before the Select Items and Services are provided to the WISeR Beneficiary and before the claim is submitted for payment.
- For expedited prior authorization requests (requests reviewed and determined within 2 days, based on determination that delays could jeopardize the beneficiary’s health or life), the request includes documentation showing that the processing of the prior authorization must be expedited due to the beneficiary’s life, health, or ability to regain maximum function being in serious jeopardy.

⁷ For guidance on how to connect to HETS, see <https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system/how-to-get-connected> and <https://www.cms.gov/files/document/current-hets-270/271-companion-guide.pdf>.

⁸ CMS. (2024). *Checking Medicare eligibility*. <https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>

⁹ WISeR Participants may find it beneficial to use Electronic Data Interchange (EDI). EDI software can facilitate automated workflows for claims submission, including eligibility verification. CMS does not have access to an EDI vendor.

1.7 WISeR Participant Issues Prior Authorization Determination

1.7.1 *Provisional Affirmation*

If the WISeR Participant determines that the applicable Medicare coverage criteria, including coding and payment rules in Chapter IV of Title 42 or in Title XVIII of the Social Security Act are met and that the Select Item or Service is appropriate for the WISeR Beneficiary, the WISeR Participant will issue a provisional affirmation of coverage to the WISeR Provider or WISeR Supplier, with a copy to the WISeR Beneficiary, in the same manner in which the request was submitted (e.g., via postmark, fax, or electronic delivery). The provisional affirmation decision will be valid for 120 days starting on the day the determination was made.

1.7.2 *Non-affirmation*

In cases where the WISeR Participant determines that that the applicable Medicare coverage criteria, including coding and payment rules in Chapter IV of Title 42 or in Title XVIII of the Social Security Act, are not met and do not support the rendering of such item or service to a WISeR Beneficiary, the WISeR Participant will issue a non-affirmation of coverage decision to the WISeR Provider or WISeR Supplier, with a copy to the WISeR Beneficiary, in the same manner in which the request was submitted (e.g., via postmark, fax, or electronic delivery).

Before issuing a non-affirmation of coverage to the WISeR Provider or WISeR Supplier, the WISeR Participant must coordinate with its WISeR Clinician(s) or WISeR Clinical Reviewer(s), as applicable, to conduct a medical review of the request and confirm that it does not meet Medicare coverage criteria.

WISeR Participants may also issue a non-affirmation of coverage if the prior authorization request contains technical errors or is otherwise insufficient to meet the requirements for provisional affirmation.

1.7.3 *Provisional Partial Affirmation*

Effective April 6, 2026, in cases where the WISeR Participant determines that one or more CPT codes for a Select Item or Service on the prior authorization request meet provisional affirmation criteria, and one or more CPT codes do not meet the criteria for affirmation, the WISeR Participant will issue a provisional partial affirmation of coverage.

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 1.7.1, and for any service(s) that receives a non-affirmation decision, as described in Section 1.7.2. WISeR Participants should indicate in the provisional partial affirmation decision any resubmission by the WISeR Provider or WISeR Supplier must only include the non-affirmed CPT code(s). For example, if a prior authorization request includes CPT codes 15271 and 15272, and the WISeR Participant issues a provisional partial affirmation in which CPT 15271 is affirmed, and CPT 15272 is non-affirmed, any resubmission should include **only** CPT code 15272 (the non-affirmed code) and should **not** include the affirmed code, CPT 15271.

Additional guidance is forthcoming regarding resubmission of provisional partial affirmations and reporting data to CMS on partial affirmations.

Note: Participants may receive a WISeR Payment for a non-affirmed Select Item or Service (provided it also meets the payment eligibility criteria outlined in Section 2.3.1) issued in a provisional partial affirmation.

1.7.4 Dismissal

In cases where the WISeR Participant determines certain information required to process the prior authorization request (e.g., MBI) is incomplete or invalid, or when the request does not fall within the scope of WISeR, the WISeR Participant will issue a dismissal. WISeR Participants may also dismiss duplicate prior authorization requests. 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). Dismissed prior authorization requests are not reviewed for medical necessity.

WISeR Participants must issue a dismissal decision in the same manner in which the request was submitted (e.g., via postmark, fax, or electronic delivery). The dismissal will outline the reason for dismissal and include instructions to submit a new initial prior authorization request and not a resubmission, if applicable. Table 4 presents several common dismissal reasons and steps to resolve.

Table 2. 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.
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.

Dismissal reason	Additional explanation	Steps to resolve
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.

1.7.5 Determination Letter: Templates and General Information

CMS will develop and provide template determination letters to WISeR Participants. Alternatively, WISeR Participants may develop their own template(s), subject to CMS' review and written approval. Additional updates to the WISeR Participant's template will require resubmission and re-approval by CMS.

At a minimum, determination letters must include the following information:

1. A UTN
2. Instructions for the WISeR Provider and/or WISeR Supplier to submit the UTN as part of their billing if the Select Item or Service is furnished
3. For prior authorization non-affirmation decisions:
 - a. Detailed explanation for the decision
 - b. Detailing of the availability of unlimited resubmissions and resubmissions for expedited review (requests reviewed and determined within 2 days, based on determination that delays could jeopardize the beneficiary's health or life) by the WISeR Provider or WISeR Supplier
 - c. Instructions for how the WISeR Provider or WISeR Supplier may request peer-to-peer review if they disagree with the non-affirmation as part of a resubmission
 - d. Explanation that there is an opportunity to forgo resubmission, provide one or more of the Select Items and Services, and submit the claim for payment; in this instance, the claim will be denied, and all Medicare appeal rights will be available
4. When the prior authorization request has been re-routed by the MAC to the WISeR Participant, determination letters must include the following information:
 - a. Contact information for the WISeR Participant
 - b. Instructions to the requesting WISeR Provider or WISeR Supplier on how it may choose to submit future prior authorization requests for Select Items and Services directly to the WISeR Participant
 - c. Any additional information that CMS may require through written notification to the WISeR Participant

Note: Like the MACs, WISeR Participants are required to redact part of the MBI when they send determination letters.¹⁰ WISeR Participants must mask the MBI on all determination letters by replacing all characters except the last four with "X"s. For example: MBI "J78Y539KD12" would be displayed as "XXXXXXXXKD12."

WISeR Participants can use the CMS logo in their determination letters but must follow CMS branding guidelines.¹¹ CMS may provide written notice via electronic delivery to the WISeR Participant regarding additional determination letter requirements.

1.7.6 Review Time Frames

Timely responses in the WISeR Model are essential for smooth operations. CMS expects that the WISeR Participant will typically issue a determination to the WISeR Provider or WISeR Supplier within 3 days of receiving the initial or resubmitted request, including requests without a UTN present. The determination will be sent in the same manner in which the request was submitted (e.g., via postmark, fax, or electronic delivery). Regardless of the manner in which the request was submitted, WISeR Participants should issue a determination in the portal within 3 days of receiving the request.

The WISeR Participant will accept unlimited resubmissions. However, any prior authorization requests received after 120 days of the initial prior authorization determination for the same WISeR Beneficiary, WISeR Provider or WISeR Supplier, and Select Item or Service will be treated as an initial prior authorization request for payment purposes.

WISeR Providers and WISeR Suppliers are permitted to request expedited reviews in certain cases. If the WISeR Participant, after consulting with the WISeR Clinician or WISeR Clinical Reviewer, concludes that waiting for a prior authorization decision could jeopardize the WISeR Beneficiary's life, health, or ability to regain maximum function, the WISeR Participant will need to communicate a determination within 2 days of receipt of the expedited request. The expedited decision will be communicated in the same manner in which it was submitted. Any services listed under the associated codes in Appendix C of the WISeR Provider and Supplier Operational Guide do not impact expedited prior authorization requests of WISeR Select Items and Services items listed in Appendix A of that guide.

Note: WISeR Providers and WISeR Suppliers are encouraged to use fax, esMD (if submitting prior authorization requests to the MAC instead of the WISeR Participant), or relevant electronic portal to avoid delays with mailing.

1.8 WISeR Provider or WISeR Supplier Requests Peer-to-Peer (P2P) Review

If a WISeR Provider or WISeR Supplier requests a peer-to-peer review for a prior authorization on resubmission, the WISeR Participant will need to connect the WISeR Provider or WISeR

¹⁰ For additional details about the requirements MACs must meet to mask MBIs on Medicare Summary Notices (MSNs): <https://www.cms.gov/files/document/r11510cp.pdf>.

¹¹ CMS. (2025). *CMS Brand Strategy & Graphic Standards Guide*. <https://www.cms.gov/about-cms/agency-information/cms-brand-identity/downloads/branding-guide.pdf>

Supplier with WISeR Clinician(s) or WISeR Clinical Reviewer(s) with specialty expertise for the condition under review. For the Peer-to-Review (P2P) process, prior authorization reviewers should prioritize the applicable National Coverage Determination (NCD) or Local Coverage Determination (LCD) along with the WISeR Clinical Documentation Requirements. Please refer to the WISeR Provider and Supplier Operational Guide for documentation requirements and references that contain clinical guidelines. The guide is available in the “Additional Information” section of the model website (<https://www.cms.gov/priorities/innovation/innovation-models/wiser>). If additional clarity is needed, reviewers may reference evidence-based guidelines consistent with national medical specialty society guidelines, if available and applicable.

A P2P prior authorization discussion must result in an actionable determination. In case of mitigating circumstances, an actional determination must be made and shared with the WISeR Provider or WISeR Supplier within 24 hours of the P2P discussion.

The WISeR Participant must make a demonstrated effort to accommodate the WISeR Provider’s or WISeR Supplier’s schedule when scheduling a requested P2P prior authorization conversation.

1.9 WISeR Participant Receives Claim for Pre-Payment Medical Review

The WISeR Model does not require WISeR Providers and WISeR Suppliers to submit prior authorization requests. However, if a WISeR Provider or WISeR Supplier does not elect to submit a prior authorization request for Select Items and Services, the WISeR Participant’s designated MAC will suspend the related claims and re-route them to the WISeR Participant for pre-payment review.

Under pre-payment review, the WISeR Participant will receive the full suspended claim from the MAC. The WISeR Participant will then need to contact the billing WISeR Provider or WISeR Supplier to request medical record documentation to support the claim, and the WISeR Provider or WISeR Supplier will have 45 days to respond to this request. CMS will regularly share additional information about Medicare-enrolled providers and suppliers to help the WISeR Participant contact the WISeR Provider or WISeR Supplier, as the claim may not have sufficient contact information. For hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs), the documentation requests 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 HOPD or ASC.

For a subset of Select Items and Services, prior authorization can only be implemented for certain indications as specified in the NCD or LCD; therefore, pre-payment medical review should be narrowed to those indications. CMS has issued further guidance on this topic, including ICD-10 codes to identify select indications, in Appendix B of the WISeR Provider and Supplier Operational Guide, which is available in the “Additional Information” section of the model website (<https://www.cms.gov/priorities/innovation/innovation-models/wiser>). In addition, for select services that include both a trial and permanent implantation of a

stimulator (as specified in the WISeR Provider and Supplier Operational Guide), the WISeR Model is initially implementing prior authorization and pre-payment review for permanent implantation of the stimulator only (trial implantations in these cases are out of scope for the WISeR Model).

After the WISeR Participant receives the requested medical record information, the WISeR Participant should use enhanced technology and its WISeR Clinicians or WISeR Clinical Reviewers, as applicable, to verify that the Select Items and Services that the WISeR Provider or WISeR Supplier already provided are consistent with Medicare coverage criteria and include:

- Adequate information from the WISeR Beneficiary's medical record to identify the WISeR Beneficiary for whom the Select Items and Services are intended;
- The intended use of the Select Items and/or Services;
- The medical condition of the WISeR Beneficiary that necessitates the use of the Select Items and Services
- Application of the criteria and clinical documentation requirements and, if applicable, relevant evidence-based clinical care guidelines for the Select Items and Services

For record retention and audit purposes, the WISeR Participant must send the MAC the medical review log along with its conclusion on paying or denying the claim when the review is complete. The WISeR Participant will issue this decision within 3 days following receipt of all documentation required to conduct the pre-payment medical review. In situations where the WISeR Provider or WISeR Supplier fails to submit the request for medical records within 45 days of the WISeR Participant's request, the WISeR Participant will notify its designated MAC that no documentation was received, and the MAC will then take action to deny the related claim.

1.10 Navigation Services

A main aim in the WISeR Model is to ensure that WISeR Beneficiaries receive clinically appropriate, high-value care, and WISeR Participants play a key role in helping WISeR Providers and WISeR Suppliers achieve that aim. Therefore, WISeR Participants will provide Navigation Services to guide WISeR Providers and WISeR Suppliers toward evidence-based, clinically appropriate care options.

At a minimum, WISeR Participants are required to take the following actions:

- Make clinical criteria, including relevant clinical care guidelines for Select Items and Services, easily accessible through the WISeR Participant's website/portal.
- Use the clinical documentation requirements defined in the WISeR Provider and Supplier Operational Guide and relevant Medicare coverage criteria (e.g., NCDs, LCDs) and established evidence-based guidelines and literature to identify and communicate clinically appropriate alternatives to the requested Items and Services for non-affirmed prior authorization determinations.
- Provide additional educational tools and resources, such as webinars and reference materials, to support WISeR Providers and WISeR Suppliers in aligning with best practices.

As part of the implementation of the WISeR exemption program in the future, CMS anticipates asking WISeR Participants to distribute performance data quarterly to WISeR Providers and WISeR Suppliers, including targeted insights for WISeR Providers and WISeR Suppliers with high non-affirmation rates for Select Items and Services. Such performance reports may include specific reasons for non-affirmation and links to educational tools and resources to support improvement.

WISeR Participants that plan to deliver Navigation Services beyond the minimum required should disclose those services to CMS. An example of other Navigation Services that the WISeR Participant may also provide includes delivering real-time nudging toward evidence-based care, based on the clinical information being entered while the WISeR Provider or WISeR Supplier is inputting data into their prior authorization request and prior to submission.

1.11 Documentation Requirements

WISeR Participants will conduct prior authorization and pre-payment medical review for the Items and Services listed in the WISeR Provider and Supplier Operational Guide. Documentation requirements, based on relevant NCDs and/or LCDs and Local Coverage Articles (LCAs), for the Select Items and Services are also available in the WISeR Provider and Supplier Operational Guide.

WISeR Participants should use the documentation requirements as the basis for assessing whether the prior authorization request should be affirmed or not affirmed. The documentation requirements should be applied uniformly across all reviews to ensure fairness and standardization in decision-making.

CMS may revise the Select Items and Services and will notify the WISeR Participant in writing, allowing the WISeR Participant to update their processes as necessary.

1.12 Claims Exclusions

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

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

1.13 Appeals

Claims for Items and Services that are subject to prior authorization or pre-payment medical review under the WISeR Model will continue to follow all existing Medicare FFS appeals procedures. WISeR Participants will need to cooperate with the appeals process as needed, including but not limited to, retaining and sharing all relevant documentation to support the determination.

For information on the appeals process, please refer to the Medicare Claims Processing Manual publication, Chapter 29, Appeals of Claims Decision.¹²

1.14 WISeR Provider and WISeR Supplier Education

WISeR Participants will educate the WISeR Providers and WISeR Suppliers within their assigned WISeR jurisdiction about the prior authorization and pre-payment medical review processes. This education will include clear instructions regarding how to access the WISeR Participant's portal, submit prior authorization requests, upload supporting documentation, and resubmit requests. This needs to occur prior to the launch of the WISeR Model and should be ongoing (tailored to the needs of the WISeR Providers and WISeR Suppliers) and designed to support WISeR Providers and WISeR Suppliers in meeting program requirements.

At a minimum, WISeR Participants, prior to the launch of the WISeR Model, should deliver at least one live or recorded webinar and conduct outreach to WISeR Providers and WISeR Suppliers. In addition, WISeR Participants should publicly post materials on their website (and the CMS website where applicable) that includes their contact information (portal website, fax, telephone number, and/or address), clear instructions for how WISeR Providers and Suppliers can submit prior authorization requests directly to the WISeR Participants, and other relevant information related to the prior authorization and pre-payment review processes.

MACs are also playing a key role in educating WISeR Providers and WISeR Suppliers. This education includes sending introductory letters to affected WISeR Providers and Suppliers, creating web postings describing the model, holding training sessions to ensure understanding of model requirements, and providing public access to supporting materials such as the WISeR Provider and WISeR Supplier Operational Guide.

1.15 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, WISeR Providers and WISeR Suppliers must do the following:

1. **Submit at least 10 prior authorization requests across WISeR Select Items and Services during an exemption assessment period.** Exemption Status will be calculated across services to help providers meet the volume threshold.

¹² CMS. (2023). *Medicare claims processing manual: Chapter 29 – Appeals of claims decisions*. <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c29pdf.pdf>

2. **Achieve a minimum affirmation threshold of 90% during an exemption assessment period.** Participants can “loosen” the threshold to less than 90% but cannot restrict it more than 90% (e.g., raise it to 99%). Assessment periods should not exceed a year (to not inadvertently penalize providers who may have started with low affirmation rates but later improved).

WISeR Participants can implement an opt-out program for providers and suppliers who do not want Exemption Status. Opt-out programs are not a requirement.

1.15.1 Communicating Exemption Program to WISeR Providers and Suppliers

WISeR Participants must publicly post their exemption program criteria and begin to deliver provider education (e.g., webinar, fact sheet) by April 1, 2026. By June 1, 2026, WISeR Participants should notify exempted WISeR Providers and WISeR Suppliers for July 2026 of their Exemption Status. In future quarters, WISeR Participants will need to continue to notify newly exempted providers and suppliers at least 30 days before the start of the quarter to inform them that they have been added to the Exemption Status list. The notification must specify the effective date of Exemption Status and the process for retaining Exemption Status.

After reevaluation is completed, WISeR Participants must notify providers and suppliers who lose Exemption Status at least 60 days before the start of the next quarter. This notification must specify the effective date of removal and the process for re-earning Exemption Status.

1.15.2 Communicating Exempt Providers to the MAC

Every quarter, WISeR Participants will communicate their list of exempt WISeR Providers and WISeR Suppliers to the MAC. These providers and suppliers will be vetted through the Center for Program Integrity to ensure they are in good standing. WISeR Participants should send CMS the quarterly list of exempt providers and suppliers on the 1st of the month preceding the list’s effective date (e.g., by June 1, 2026, for the July 2026 file) to allow time for vetting. CMS will notify the WISeR Participants of any providers or suppliers that need to be removed from the exemption list due to not being in good standing. Subsequently, WISeR Participants should send the vetted list of exempt WISeR Providers and WISeR Suppliers to the MAC by the 15th of the month preceding the list’s effective date (e.g., by June 15, 2026, for the July 2026 file).

MACs will not forward prior authorization requests from exempted providers and suppliers to the WISeR Participants. WISeR Participants should dismiss such requests and educate the submitting provider on their Exemption Status. MACs will also forward WISeR-relevant claims from these providers and suppliers to model participants on a monthly basis (to be used in reevaluation of their Exemption Status).

1.15.3 Reevaluation

Exempted WISeR Providers and Suppliers will maintain their status for at least 1 year (or longer at the discretion of the model participant). WISeR Participants will reevaluate Exemption Status through issuing no more than 10 Additional Documentation Requests (ADRs) per year and using other reasonable means (which must be disclosed to CMS and providers). As part of the ADR review, if the model participant determines a claim does not meet medical necessity, they will

notify the MACs to recoup payment for that claim. The Exemption Status would remain in effect until CMS and/or the WISeR Participant elects to withdraw the Exemption Status based on performance; in this case, WISeR Providers and WISeR Suppliers would be given adequate advance notice before the Exemption Status is withdrawn.

2 WISeR Payment Methodology

WISeR Participants receive payments based on a share of the savings attributable to their implementation of both prior authorization and pre-payment review. The following sections detail the methodology for conducting reconciliation and calculating WISeR Payments.

2.1 Prior Authorizations and Pre-Payment Reviews

Prior authorization is a review process conducted by the WISeR Participant before the WISeR Provider or WISeR Supplier furnishes the relevant Select Item or Service to a Medicare beneficiary. By contrast, pre-payment review is conducted after the WISeR Provider or WISeR Supplier furnishes the Select Item or Service and bills it to Medicare, but before the claim is paid.¹³

For the purpose of calculating WISeR Payments, each prior authorization request is treated as an initial request or a resubmission. A prior authorization request is considered an initial request if either of the following occurs:

- The submitting WISeR Provider or WISeR Supplier has not previously submitted a prior authorization request for the identical Select Item or Service and WISeR Beneficiary.
- The request is submitted at least 120 days after the determination was issued for a previous initial request submitted by the same WISeR Provider or WISeR Supplier for the same Select Item or Service and WISeR Beneficiary.

For the purpose of calculating WISeR Payments, resubmissions are prior authorization requests submitted by the same WISeR Provider or WISeR Supplier within 120 days of the determination for their initial request involving the same Select Item or Service and WISeR Beneficiary. (Although unlimited resubmissions are available to WISeR Providers and WISeR Suppliers, a resubmission submitted more than 120 days after the determination for the initial prior authorization request is treated as a new initial request for payment purposes.) Details about calculating WISeR Payments for prior authorization and WISeR Payments for pre-payment review are provided in Section 2.3 and Section 2.4, respectively.

2.2 WISeR Agreement Periods and Performance Periods

¹³ Pre-payment review takes place if the provider or supplier billed the Select Item or Service without first requesting prior authorization. If a provider or supplier bills a Select Item or Service for a given beneficiary after a non-affirmed prior authorization determination, the claim is denied and does not go through pre-payment medical review.

WISeR began on January 1, 2026, and will conclude on December 31, 2031. The 6-year model test is divided into two 3-year agreement periods and further subdivided into quarterly performance periods for reconciliation and payment purposes.

For reconciliation purposes, each performance period includes:

- All initial prior authorization determinations issued during the performance period
- All resubmissions linked to an initial prior authorization determination that was issued during the performance period
- All pre-payment review determinations issued during the performance period

Table 3 notes the key dates associated with each performance period. As resubmissions may be submitted up to 120 days after the initial prior authorization determination, a portion of the resubmissions included in a given performance period may be submitted after the final day of the performance period.

Table 3. WISeR agreement periods and performance periods

Performance period (PP)	Year	Start date	End date	Last day for resubmissions	Agreement period
PP1	2026	1/1/2026	3/31/2026	7/28/2026	1
PP2	2026	4/1/2026	6/30/2026	10/27/2026	1
PP3	2026	7/1/2026	9/30/2026	1/27/2027	1
PP4	2026	10/1/2026	12/31/2026	4/29/2027	1
PP5	2027	1/1/2027	3/31/2027	7/28/2027	1
PP6	2027	4/1/2027	6/30/2027	10/27/2027	1
PP7	2027	7/1/2027	9/30/2027	1/27/2028	1
PP8	2027	10/1/2027	12/31/2027	4/28/2028 ^a	1
PP9	2028	1/1/2028	3/31/2028	7/28/2028	1
PP10	2028	4/1/2028	6/30/2028	10/27/2028	1
PP11	2028	7/1/2028	9/30/2028	1/27/2029	1
PP12	2028	10/1/2028	12/31/2028	4/29/2029	1
PP13	2029	1/1/2029	3/31/2029	7/28/2029	2
PP14	2029	4/1/2029	6/30/2029	10/27/2029	2
PP15	2029	7/1/2029	9/30/2029	1/27/2030	2
PP16	2029	10/1/2029	12/31/2029	4/29/2030	2
PP17	2030	1/1/2030	3/31/2030	7/28/2030	2
PP18	2030	4/1/2030	6/30/2030	10/27/2030	2
PP19	2030	7/1/2030	9/30/2030	1/27/2031	2
PP20	2030	10/1/2030	12/31/2030	4/29/2031	2
PP21	2031	1/1/2031	3/31/2031	7/28/2031	2
PP22	2031	4/1/2031	6/30/2031	10/27/2031	2
PP23	2031	7/1/2031	9/30/2031	1/27/2032	2
PP24	2031	10/1/2031	12/31/2031	4/29/2032	2

^a The last day for PP8 resubmissions is April 28 rather than April 30 due to the leap day on February 29, 2028.

2.3 WISeR Payments for Prior Authorization

2.3.1 Eligibility for Payment

CMS uses the term “payable non-affirmations” to refer to prior authorization determinations that meet the criteria to qualify for a WISeR Payment. Except in one circumstance described later in this subsection, a payable non-affirmation must be an initial prior authorization determination (i.e., not a resubmission within 120 days of an earlier initial prior authorization determination involving the identical WISeR Beneficiary, Select Item or Service, and WISeR Provider or WISeR Supplier).

A prior authorization determination must meet the following additional criteria to qualify for a WISeR Payment:

- The determination is a non-affirmation.
- This non-affirmation was not overturned by a subsequent resubmission that was submitted within 120 days of the initial prior authorization determination and provisionally affirmed.
- Based on data available at the time of reconciliation for the relevant performance period, Medicare did not pay an associated claim due to a successful claims appeal of a claim denial.
- The submitting WISeR Provider or WISeR Supplier was not exempt on the date the prior authorization request was submitted.
- When the prior authorization request was submitted, no valid provisional affirmation determination was already in effect for the applicable WISeR Provider or WISeR Supplier, Select Item or Service, and WISeR Beneficiary due to a previously submitted request for prior authorization.
- The prior authorization request includes the minimum necessary data elements required for WISeR Payment calculations (MBI, NPI, Select Item or Service, and place of service and physical address of the expected place of service).

The non-affirmation of a resubmission may qualify as a payable non-affirmation and result in a WISeR Payment only if *both* of the following conditions are met:

- The associated initial prior authorization determination failed to qualify as a payable non-affirmation solely because one or more of the minimum necessary data elements required for WISeR Payment calculations were missing from the prior authorization request.
- The resubmission in question is the first resubmission of this prior authorization request to meet all criteria for a payable non-affirmation.

CMS calculates the WISeR Payment for the payable non-affirmation of an Add-On Service separately from the WISeR Payment for the payable non-affirmation of any other Select Item or

Service, potentially resulting in two distinct WISeR Payments associated with the same prior authorization request.

Please note that WISeR Payments for non-affirmations are subject to future recoupment in the event of a successful claims appeal (see Section 2.5 for more information on WISeR Recoupments).

2.3.2 Regional Benchmark

The regional benchmark reflects the typical Medicare spending (less any beneficiary cost-sharing amounts) associated with a particular Select Item or Service in a specific geographic area, based on recent Medicare claims data. CMS calculates this regional benchmark to represent Medicare spending averted¹⁴ by each prior authorization non-affirmation of a Select Item or Service. CMS calculates a locality-specific regional benchmark for each Select Item or Service for each performance period.

The detailed methodology for calculating these regional benchmarks is described in the following sections. In most circumstances, CMS calculates regional benchmarks for Select Items and Services that are not Add-On Services via the historical pricing method outlined in Section 2.3.2. Section 2.3.4 describes an alternative method (comparison pricing) that CMS may temporarily use to calculate regional benchmarks for one or more Select Items and Services that are not Add-On Services in the event of new legislation or Medicare payment policy changes that could create a temporary mismatch between historical and current utilization and payment patterns. Section 2.3.5 describes the methodology that CMS uses to calculate the regional benchmarks for Add-On Services.

2.3.3 Historical Pricing

When calculating the regional benchmark via historical pricing for a Select Item or Service that is not an Add-On Service, CMS uses data from qualifying historical claims with a date of service within the 12 months preceding the start of the relevant performance period.

For the purpose of calculating a regional benchmark via historical pricing for a specific Select Item or Service in a specific locality, qualifying claims must:

- Include an approved payment for the pertinent Select Item or Service
- Be submitted in the state that includes the pertinent locality
- Be submitted with a date of service in the 12 months preceding the first day of the applicable performance period

After identifying these qualifying claims, CMS calculates the regional benchmark as follows:

1. CMS identifies any items or services billed on qualifying claims that are excluded from WISeR Payment calculations. The current list of exclusions is provided in Section 2.8.
2. CMS adjusts the payments for all non-excluded items and services billed on the qualifying claims (including the pertinent Select Item or Service and potentially other

¹⁴ Because prior authorization takes place before the submission of a claim, the amount that would have been billed in the absence of WISeR on any specific Medicare claim is unknown.

non-excluded items and services) to reflect current Medicare payment rates for the relevant locality in the year in which the applicable performance period occurred. Beneficiary cost-sharing amounts are excluded from these payments.

3. CMS calculates the encounter-level payment by totaling the adjusted payments for all non-excluded items and services billed on the qualifying claim(s).
4. CMS calculates the regional benchmark as the average encounter-level payment among all qualifying claims for the Select Item or Service in the state that includes the relevant locality.

2.3.4 Comparison Pricing

If newly enacted legislation and/or Medicare payment policy changes significantly alter the spending and utilization patterns for a WISeR Select Item or Service during the model test, historical claims that predate these changes may not accurately reflect the spending averted by prior authorization during the performance period. In this circumstance, CMS may temporarily use comparison pricing as an alternative methodology for calculating the regional benchmark for any affected Select Items or Services that are not Add-On Services.

For the purpose of calculating a regional benchmark via comparison pricing for a specific Select Item or Service in a specific locality, qualifying claims must:

- Include an approved payment for the pertinent Select Item or Service
- Be submitted in the MAC jurisdiction that includes the pertinent locality
- Be submitted with a date of service that is no earlier than the effective date of the policy change and/or legislation that precipitated the temporary use of comparison pricing
- Be submitted with a date of service that is no later than the last day of the performance period for which the regional benchmark applies

After identifying these qualifying claims, CMS calculates the regional benchmark as follows:

1. CMS identifies any items or services billed on qualifying claims that are excluded from WISeR Payment calculations. (The current list of exclusions is provided in Section 2.8.)
2. CMS adjusts the payments for all non-excluded items and services billed on the qualifying claims (including the pertinent Select Item or Service and potentially other non-excluded items and services) to reflect current Medicare payment rates for the relevant locality in the year in which the applicable performance period occurred. Beneficiary cost-sharing amounts are excluded from these payments.
3. CMS calculates the encounter-level payment by totaling the adjusted payments for all non-excluded items and services billed on the qualifying claim(s).
4. CMS calculates the regional benchmark as the average encounter-level payment among all qualifying claims for the Select Item or Service in the MAC jurisdiction that includes the relevant locality.

If CMS temporarily switches to the comparison pricing method to calculate the regional benchmarks for a given Select Item or Service, CMS will revert to the historical pricing method

starting in the first performance period whose start date is at least 12 months after the effective date for the relevant policy change or legislation. (In other words, CMS will resume the use of historical pricing for the applicable WISeR Select Item or Service once the standard 12-month historical period no longer contains claims whose dates of service precede the relevant policy change or legislation.)

Please note that CMS determinations on whether to use historical pricing or comparison pricing to calculate regional benchmarks are made separately for each Select Item or Service in each performance period, with historical pricing as the default approach. Because the purpose of comparison pricing is to maintain the accuracy of regional benchmarks immediately following a policy change with direct implications for a Select Item or Service, CMS may switch to comparison pricing for one or more specific Select Items and Services while continuing to use historical pricing for other Select Items and Services.

2.3.5 Add-On Services

For each Select Item or Service that is an Add-On Service, CMS calculates the regional benchmark as the Medicare payment amount set forth in the applicable Medicare fee schedule(s) for the applicable locality and calendar year.

2.3.6 WISeR Discount

The WISeR Discount is an adjustment reflecting potential Medicare spending that MACs have historically averted through pre-prepayment reviews and post-payment audits of claims for Select Items and Services. These are savings that predate WISeR and are excluded from WISeR Payments because they cannot be attributed to the WISeR Participant's prior authorization and pre-payment review processes.

Separately by state, CMS calculates the WISeR Discount for each WISeR Select Item or Service using historical claims for that item or service with a date of service in calendar year 2025 (CY2025). For a given state and Select Item or Service, the WISeR Discount is calculated as the medical-necessity denial rate across all claims for the pertinent Select Item or Service submitted within the state with a date of service in CY2025.

Because the WISeR Discount is meant to capture the level of spending averted before the implementation of WISeR, it is not routinely updated for each performance period. CMS will provide advance written notice of any modifications to the WISeR Discount.

2.3.7 WISeR Payment Rate

The WISeR payment rate of 25% determines the portion of the regional benchmark that a WISeR Participant is potentially eligible to receive as a WISeR Payment for each payable non-affirmation, subject to further adjustments, including the WISeR Discount and the quality adjustment. The WISeR payment rate does not vary between Select Items and Services or between localities.

2.3.8 Quality Multiplier

WISeR Payments are subject to a quality multiplier reflecting the WISeR Participant’s aggregate performance on quality measures. Detailed technical information and other technical documentation concerning the specifications and scoring for individual quality measures are provided in the WISeR Data Reporting Guide.

During the reconciliation of each performance period, CMS calculates an Aggregate Quality Score (AQS) for each WISeR Participant. The AQS indicates the points earned by the WISeR Participant on quality measures as a percentage of all quality points available for that performance period:

$$AQS = \frac{\text{Quality Points Earned}}{\text{Quality Points Available}} * 100$$

The WISeR Participant’s AQS determines the quality multiplier that CMS applies to each WISeR Payment for that performance period. Table 3 displays the AQS ranges that correspond to each potential value of the quality multiplier.

Table 3. AQS and quality multiplier values

AQS range (%)	Quality multiplier (%)
85–100	100
60–84	95
<60	90

2.3.9 Calculation of the WISeR Payment

After identifying payable non-affirmations per the eligibility criteria outlined in Section 2.3.1, CMS calculates the WISeR Payment for each payable non-affirmation as follows:

1. CMS determines the regional benchmark for the applicable WISeR Select Item or Service in the appropriate locality (see Section 2.3.2).
2. CMS reduces the regional benchmark by the WISeR Discount for the applicable Select Item or Service in the relevant state (see Section 2.3.6).
3. CMS applies the WISeR Payment rate (see Section 2.3.7).
4. CMS applies the WISeR Participant’s quality multiplier for the applicable performance period (see Section 2.3.8).

2.4 WISeR Payments for Pre-Payment Review

2.4.1 Eligibility for Payment

A pre-payment review determination qualifies for a WISeR Payment if the following conditions are met:

- The determination for the pre-payment review is a denial of the associated claim (or denial of the line item associated with the Select Item or Service, if multiple items and services are billed together on the same claim).

- At the time of reconciliation for the relevant performance period, the denial of the claim (or line item) for the Select Item or Service has not been successfully appealed.

Please note that WISeR Payments for pre-payment reviews are subject to future recoupment in the event of a successful claims appeal (see Section 2.5 for more information on WISeR Recoupments).

2.4.2 Averted Spending

If a pre-payment review determination qualifies for a WISeR Payment, CMS calculates the spending averted by the pre-payment review as follows:

1. CMS calculates and totals the Medicare payment amounts (less any beneficiary cost-sharing) applicable to the items and services billed on the associated claim.
2. CMS subtracts any payments for items and services other than the relevant WISeR Select Item or Service that were billed as line items on the same claim and were not denied.
3. CMS subtracts any payments for items or services billed on the same claim that are excluded from WISeR Payment calculations. (The current list of WISeR claim-level payment exclusions is provided in Section 2.8.)

2.4.3 WISeR Discount

The WISeR Discount is an adjustment reflecting potential Medicare spending that MACs have historically averted through pre-prepayment reviews and post-payment audits of claims for Select Items and Services. These are savings that predate WISeR and are excluded from WISeR Payments because they cannot be attributed to the WISeR Participant's prior authorization and pre-payment review processes.

CMS calculates the WISeR Discount separately by state for each Select Item or Service; for a given Select Item or Service in a given state, the same WISeR Discount applies to WISeR Payments for both prior authorization and pre-payment review. The methodology for calculating the WISeR Discount is described in Section 2.3.6.

2.4.4 WISeR Payment Rate

The WISeR Payment rate of 25% determines the portion of averted spending that a WISeR Participant is potentially eligible to receive for each eligible pre-payment review resulting in a denied claim, subject to further adjustments, including the WISeR Discount and the quality adjustment. The WISeR payment rate does not vary between Select Items and Services or between localities.

2.4.5 Quality Multiplier

WISeR Payments are subject to a quality multiplier reflecting the WISeR Participant's aggregate performance on quality measures. Detailed technical information and other technical documentation concerning the specifications and scoring for individual quality measures are provided in the WISeR Data Reporting Guide.

The methodology for calculating the AQS and determining the corresponding quality multiplier is described in Section 2.3.8.

2.4.6 Calculation of WISeR Payment for Pre-Payment Review

After determining that a pre-payment review determination qualifies for a WISeR Payment per the eligibility criteria outlined in Section 2.4.1, CMS calculates the WISeR Payment as follows:

1. CMS calculates the spending averted by the pre-payment review (see Section 2.4.2).
2. CMS reduces this averted spending amount by the WISeR Discount (see Sections 2.3.6 and 2.4.3).
3. CMS applies the WISeR payment rate (see Section 2.4.4).
4. CMS applies the WISeR Participant's quality multiplier for the applicable performance period (see Sections 2.3.8 and 2.4.5).

2.5 WISeR Recoupments

The MAC will deny a claim for a Select Item or Service if the claim is submitted (1) following a prior authorization non-affirmation (without any affirmed resubmission) or (2) without a prior authorization request, and the WISeR Participant's pre-payment review determination is a denial. In these circumstances, WISeR Providers, WISeR Suppliers, and WISeR Beneficiaries retain their statutory rights to appeal the claim denial. If an appeal is successful and Medicare ultimately pays the WISeR Provider or WISeR Supplier for furnishing the Select Item or Service to the relevant beneficiary, the original prior authorization non-affirmation or pre-payment review denial is no longer eligible for a WISeR Payment.

As noted in Sections 3.1 and 4.1, a prior authorization determination or pre-payment review determination is not eligible for a WISeR Payment if an associated claim denial has been successfully appealed as of the time that CMS conducts reconciliation for the relevant performance period. If a claim denial linked to a prior authorization determination or pre-payment review is successfully appealed after CMS has already made an associated WISeR Payment, CMS will recoup the WISeR Payment from the WISeR Participant.

During reconciliation, CMS identifies any recently adjudicated claims appeals that may nullify a WISeR Payment that has not yet been paid or that triggers a WISeR Recoupment. Please note that, given the variable timing of claims appeals, the WISeR Payments to be recouped may include WISeR Payments made for multiple previous performance periods. Whenever possible, any outstanding WISeR Recoupments identified by CMS are netted against upcoming WISeR Payments. The reconciliation report for each performance period indicates whether any recoupments have been netted against the WISeR Payments for that performance period. If it is not possible to net WISeR Recoupments against future payments, CMS will issue a demand letter for the amount to be recouped.

2.6 Reconciliation Process

CMS conducts reconciliation no earlier than 120 days following the last day of the performance period. This 120-day payment hold allows CMS to identify all resubmissions that fall within the performance period, including those linked to an initial prior authorization determination that

was issued relatively late in the performance period. Table 2 in Section 2.2 provides the final date on which resubmissions may potentially be submitted for each performance period.

WISeR Participants are required to submit certain data to CMS for each performance period to inform reconciliation calculations and quality scoring. The required data elements and the process for submitting these data to CMS are described in the WISeR Data Reporting Guide.

After receiving the required data from the WISeR Participant, CMS identifies each payable non-affirmation issued by the participant during the performance period and each pre-payment review determination that qualifies for a WISeR Payment. CMS calculates the WISeR Payment for each payable non-affirmation using the methodology described in Section 2.3 and calculates the WISeR Payment for each qualifying pre-payment review using the methodology described in Section 2.4. After calculating these individual WISeR Payments, CMS totals the payments earned by the WISeR Participant for the performance period.

When applicable, this total payment will be netted against:

- Any outstanding WISeR Recoupments that the WISeR Participant owns
- Any advance WISeR Payment that CMS has already paid to the WISeR Participant for the same performance period (see Section 2.7 for more information)

When reconciliation is complete, CMS will issue a reconciliation report to each WISeR Participant detailing the WISeR Payment calculations, quality performance, and the amount of the total WISeR Payment that will be paid to the participant for this performance period. (If the WISeR Participant owes CMS a net recoupment due to WISeR Recoupments and/or the netting of an advance WISeR Payment, the reconciliation report will indicate the amount to be recouped.) WISeR Participants may contest any suspected errors in the reconciliation calculations before the report is deemed final and any payments or recoupments are processed.

2.7 Advance WISeR Payment

In certain performance periods (and at the sole discretion of CMS), CMS may pay an advance WISeR Payment to each WISeR Participant based on 50% of the projected total WISeR Payment that the WISeR Participant will earn for that performance period. The advance WISeR Payment amount is netted against the total WISeR Payment calculated when CMS formally conducts reconciliation for that performance period.

If CMS offers the opportunity to receive an advance WISeR Payment, the WISeR Participant must submit preliminary data for the relevant performance period to CMS to receive an advance WISeR Payment. These data are submitted to CMS shortly after the performance period ends and reflect the best available data at the time of submission. Additional details about data submission for calculating an advance WISeR Payment are included in the WISeR Data Reporting Guide. Although submission of these preliminary data is optional, a WISeR Participant that does not share these data upon request will not be eligible to receive an advance WISeR Payment for the relevant performance period.

After receiving preliminary data from the WISeR Participant, CMS estimates the total WISeR Payment for the performance period. First, CMS provisionally identifies the payable non-

affirmations and qualifying pre-payment review determinations issued by the WISeR Participant during the performance period. Next, CMS estimates the WISeR Payment for each payable non-affirmation and qualifying pre-payment review. Although the methodology for estimating the WISeR Payment largely aligns with the approaches outlined in Sections 2.3 and 2.4, the advance WISeR Payment does not include a quality adjustment because the necessary data are not available until the formal reconciliation of the performance period.

To estimate the WISeR Payment for a payable non-affirmation, CMS determines the applicable regional benchmark (based on the performance period, locality, and specific Select Item or Service), reduces it by the applicable WISeR Discount, and multiplies the result by the WISeR payment rate of 25%.

To estimate the WISeR Payment for a qualifying pre-payment review, CMS calculates the averted spending for the claim using the methodology outlined in Section 2.4.2, reduces the amount by the applicable WISeR Discount, and multiplies the result by the WISeR payment rate of 25%.

After estimating the individual WISeR Payments earned by the WISeR Participant for the performance period, CMS calculates the advance WISeR Payment by summing these estimated WISeR Payments and multiplying the total by 50%. The calculation of the advance WISeR Payment cannot be contested.

Please be aware that the calculation of the advance WISeR Payment is a projection based on preliminary data and does not constitute any guarantee from CMS regarding the total WISeR Payment amount that is calculated during the formal reconciliation of the performance period. Notably, the advance WISeR Payment is calculated before the final day for prior authorization resubmissions; consequently, prior authorization determinations that appear eligible for payment when CMS calculates the advance may not necessarily qualify as payable non-affirmations when CMS conducts reconciliation for the performance period. As noted in Section 2.6, the amount of the advance WISeR Payment already paid to the WISeR Participant is netted against the total WISeR Payment that CMS calculates during reconciliation.

If CMS offers an advance WISeR Payment for a given performance period, CMS will make reasonable efforts to issue it by the end of the second month following the performance period. However, CMS does not guarantee the timing of the advance WISeR Payment.

2.8 Payment Exclusions

Several WISeR reconciliation processes require the calculation of a total payment across one or more Medicare claims that include a Select Item or Service. These processes include:

- The calculation of the regional benchmark via historical pricing (Section 2.3.3)
- The calculation of the regional benchmark via comparison pricing (Section 2.3.4)
- The calculation of averted spending for a pre-payment review (Section 2.4.2)

When calculating these payment totals, CMS excludes certain items and services that are not Select Items and Services but could theoretically be billed as line items on the same claim(s) as a WISeR Select Item or Service. CMS maintains a list of these exclusions in the WISeR Participant

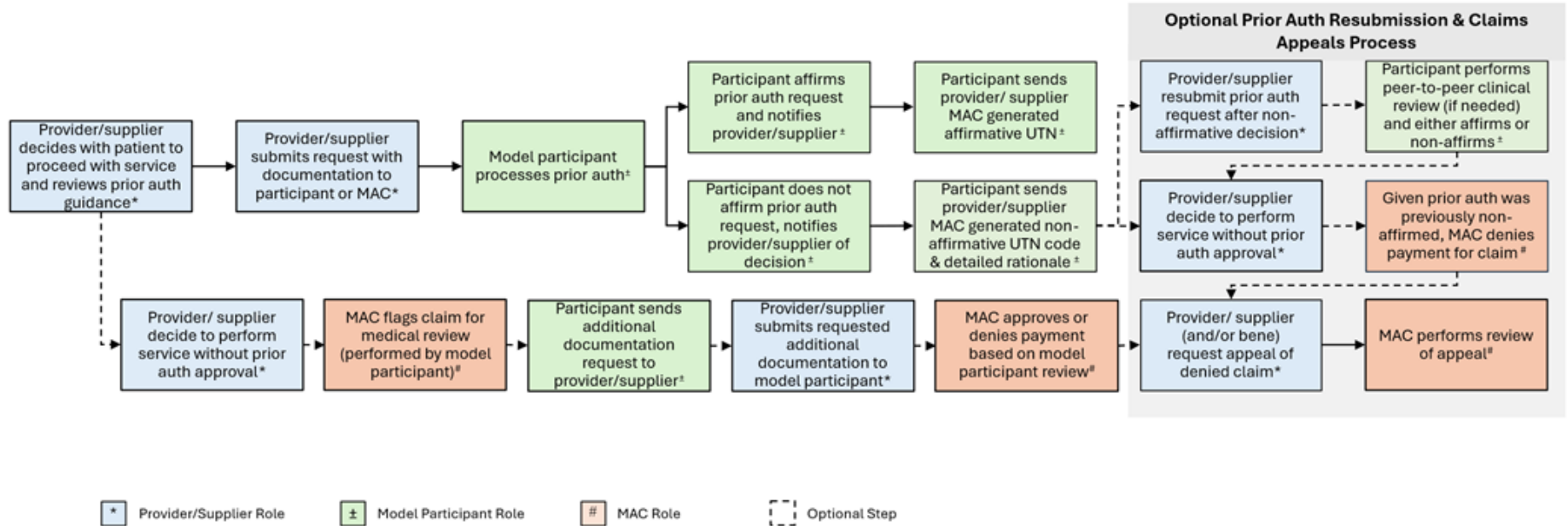
Guide. CMS may update this list of payment exclusions and will make reasonable efforts to provide advance written notice of such updates to WISeR Participants.

Effective starting in Performance Period 1 (PP1), payment exclusions include any item or service billed with a date of service that does not match the date of service for the Select Item or Service billed on the claim.

Additionally, when calculating the regional benchmark for a given Select Item or Service, CMS excludes any associated Add-On Service(s) that separately qualify as a Select Item or Service. This exclusion applies only to regional benchmark calculations and does not apply to the averted spending that CMS calculates as a component of the WISeR Payment for a pre-payment review.

Appendices

Appendix A. WISer Process Flowchart



Appendix B: Acronym Glossary

AQS: Aggregate Quality Score

ARS: Acceptable Risk Standards

ASC: Ambulatory Surgical Center

BAA: Business Associate Agreement

BPSSM: Business Partners Systems Security Manual

esMD: Electronic Submission of Medical Documentation

FISMA: Federal Information Security Modernization Act

FFS: Fee-for-service

HETS: HIPAA Eligibility Transaction System

HIPAA: Health Information Privacy and Portability Act

HOPD: Hospital Outpatient Departments

IME: Indirect Medical Education

IS2P2: Information Systems Security & Privacy Policy

JOA: Joint Operating Agreement

LCA: Local Coverage Articles

LCD: Local Coverage Determination

MAC: Medicare Administrative Contractor

MBI: Medicare Beneficiary Identifier

NCD: National Coverage Determination

NPI: National Provider Identifier

OPD: Outpatient Department

P2P: Peer-to-Peer

UTN: Unique Tracking Number

WISeR Model: Wasteful and Inappropriate Service Reduction (WISeR) Model