

WISeR Model Payment Methodology

WISeR Participants may be eligible to receive payments based on a share of the savings attributable to their implementation of both prior authorization and pre-payment review. WISeR does not change Medicare coverage criteria or the amount that Medicare may pay for items and services furnished to beneficiaries. Medicare coverage criteria is determined by statute, regulation, national coverage determinations (NCDs) and local coverage determinations (LCDs). WISeR Participants are expected to use existing Medicare coverage criteria and follow Medicare programmatic requirements to ensure that appropriate care is provided to beneficiaries and reduce potential harm.

Participants may earn payment for non-affirmation of a **prior authorization** request for a WISeR item or service, *if* it does *not* meet Medicare coverage criteria. The determination must be a unique request and must not have been overturned on resubmission or by appeal. Additionally, the participant must submit required data, including information related to prior authorization and pre-payment review determinations, in accordance with CMS reporting requirements, and meet CMS's performance standards.

The WISeR payment that CMS pays to a WISeR Participant for a qualifying non-affirmation is based on a regional benchmark, calculated as the average encounter-level Medicare spending for the WISeR item or service using historical or comparison pricing. After determining the regional benchmark, CMS also applies the WISeR discount, the WISeR payment rate, and the WISeR Participant's specific quality adjustment to obtain the final WISeR payment amount. Note that regional benchmarks are calculated separately for each WISeR item or service in each performance period and for each WISeR geographical area. For more information on WISeR payments for prior authorization, see Section 2.3 of the WISeR Participant Guide.

If a WISeR provider or WISeR supplier chooses not to request prior authorization, claims are routed for **pre-payment review**. A participant may receive a WISeR payment for each pre-payment review that results in a denied claim for a WISeR item or service *if* the claim does *not* meet Medicare coverage criteria. Each WISeR payment for a qualifying pre-payment review is calculated by determining the averted spending (the total Medicare payment amount that would have been paid for the denied services) and then applying the WISeR discount, WISeR payment rate, and quality adjustment (reflecting the WISeR Participant's accuracy and timeliness). CMS will withhold or recoup the WISeR payment for a pre-payment review if the denied claim is successfully appealed. For more information on WISeR payments for pre-payment review, see Section 2.4 of the WISeR Participant Guide.

CMS reduces WISeR payments for qualifying non-affirmations and pre-payment reviews if the participant fails to meet accuracy and timeliness standards. Determination accuracy and timeliness results inform participants' quality scores and may result in payment reductions for determinations that are inaccurate or that do not meet turnaround time expectations. CMS may impose remedial actions like imposition of a corrective action plan, non-payment or payment withholds, or termination from the Model for poor performance. Poor performance can include inaccuracies in determinations, failure to comply with data reporting or determination communication requirements, or inadequate outreach/education efforts to providers.

WISeR Safeguards to Support Appropriate Determinations

WISeR incorporates multiple safeguards to promote accurate, timely, and transparent prior authorization and pre-payment review determinations. The WISeR payment methodology is designed to discourage inappropriate non-affirmations through several mechanisms:

Human review required: Every non-affirmation must undergo a medical review by an appropriately licensed WISeR clinician or WISeR clinical reviewer to confirm the request does not meet Medicare coverage criteria. There is no limit on the number of times WISeR providers and suppliers can resubmit non-affirmed prior authorization requests, and WISeR providers and suppliers may request a peer-to-peer clinical review of each resubmission. If a WISeR provider or WISeR supplier does not submit a prior authorization request for a WISeR item or service, then the claim is subject to pre-payment review. As a safeguard, a WISeR clinician or WISeR clinical reviewer conducts medical review for each pre-payment review claim to determine whether Medicare coverage criteria are met.

CMS auditing and quality scoring: CMS will regularly audit participants to verify that determinations align with Medicare coverage criteria. CMS also measures performance on timeliness and other metrics. In the future, CMS may adjust payments to participants based on additional performance metrics.

Single payment per beneficiary: Participants receive only one payment per beneficiary for a given WISeR item or service, regardless of how many times a request is resubmitted. This structure incentivizes accurate determinations on the first review because WISeR Participants must pay for all costs related to processing prior authorization requests, including any number of resubmissions for non-affirmed determinations.

Appeal rights and WISeR payment recoupment: Providers, suppliers, and beneficiaries continue to have all applicable administrative appeal rights under Medicare. WISeR Participants will not receive payment, and may face recoupment, for non-affirmations or denials that are subsequently overturned through a successful claims appeal.

Stakeholder Feedback: CMS continues to review stakeholder feedback and will refine WISeR model operations as appropriate. Providers or suppliers with questions about individual determinations or the participant portal should contact the WISeR Participant responsible for their jurisdiction. Contact information is in the WISeR Provider and Supplier Operational Guide: <https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf>.

Beneficiaries with questions about their care or a determination should contact their provider or supplier. Stakeholders may also contact CMS via the WISeR helpdesk: WISeR@cms.hhs.gov.