WISeR Performance Measure Technical Specifications for Performance Period (PP) 1

WISeR-1: Timeliness of Determinations

Measure Description

The percentage of WISeR service prior authorization requests and pre-payment reviews that had a determination issued within the prescribed timeframe:

- Initial requests, resubmissions, and pre-payment reviews within 3 calendar days
- Expedited requests within 2 calendar days

Use of Measure by Performance Period (PP) for 2026

- PP1: 1/1/2026 – 3/31/2026 – Pay for reporting

Scoring

Proportion.

Type

Process.

Data Source

Participant-reported data.

Stratifications

None.

Risk Adjustment

None.

Improvement Notation

A higher percentage indicates better performance.

Definitions

Initial Prior Authorization Submission: A request by a WISeR Provider or WISeR Supplier for provisional affirmation for one of the select items and services prior to furnishing such items and services to the WISeR Beneficiary and before the claim is submitted for processing.

Expedited Submission: Prior authorization request from a WISeR Provider or Supplier and confirmed by a WISeR Participant that indicates that delays could jeopardize the life, health, or ability to regain maximum function of the WISeR Beneficiary. The WISeR Participant will communicate a determination within 2 calendar days of receipt of the expedited request.

Resubmission: Submissions within 120 calendar days of an initial prior authorization determination for a prior authorization previously submitted by the same WISeR Provider or WISeR Supplier for the same WISeR Beneficiary and for the same item or service. Resubmissions are counted as separate denominator events for this measure.

Pre-payment Review: A review by the WISeR Participant to verify consistency with Medicare Coverage Criteria for a claim for one or more select items and services furnished in the MAC Jurisdiction that is submitted for payment without requesting prior authorization.

Guidance

For reporting, resubmissions of initial determinations made during the performance period are included in the performance period in which the initial determination was made.

Initial Population

Measure item count: Initial prior authorization requests, resubmissions, and pre-payment reviews for WISeR services in the following states:

- Arizona
- New Jersey
- Ohio
- Oklahoma
- Texas
- Washington

All determinations associated with prior authorization requests or pre-payment reviews issued during the performance period. This includes the following:

- Determinations for initial prior authorization or pre-payment review issued during the performance period
- Determinations for resubmissions related to initial determinations issued within the performance period

Denominator Exclusions

Prior authorization request or pre-payment review that does not have a determination within the performance period.

Dismissed prior authorization request(s) or ineligible pre-payment review(s).

Denominator

Identify all prior authorization requests or pre-payment reviews with a determination date during the performance period that include a procedure code (paired with a diagnosis code, where applicable) for a WISeR service listed in the WISeR Model Provider and Supplier Operational Guide[1]. Include the following:

[1] https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf

- *Initial* prior authorization requests or pre-payment reviews with a determination date during the performance period that include a procedure code (paired with a diagnosis code, where applicable) for a WISeR service
- *Resubmissions* of initial prior authorization requests with determination dates during the performance period

Numerator

For each request or review, identify whether the time elapsed between the date the request was received and the date the determination was issued met the criteria below. Day counting is inclusive, meaning the date the request is received counts as Day 1. For example, a request received on January 1 with a determination issued on January 3 has elapsed 3 calendar days and meets the 3-day standard. A determination issued on January 4 would not meet the standard.

1. Identify the *non-expedited* prior authorization requests, resubmissions and pre-payment reviews for which a determination was issued within 3 calendar days.
2. Identify the *expedited* prior authorization requests for which a determination was issued within 2 calendar days.
3. Sum 1 and 2 to determine the numerator.

Scoring WISeR-1

WISeR-1 will be scored on a pay-for-reporting basis through at least PP3. In accordance with the WISeR Participation Agreement, CMS will provide advance written notice before the start of the applicable performance period if CMS changes the basis for scoring WISeR-1.

WISeR-2: Accuracy of Determinations

Measure Description

The percentage of audited WISeR prior authorization and pre-payment review determinations that are consistent with the Medicare coverage criteria for the relevant item or service.

Use of Measure by Performance Period (PP) for 2026

PP1: 1/1/2026 – 3/31/2026 – Pay for reporting

Scoring

Proportion.

Type

Process.

Data Source

Participant-reported data, claims data, medical record data, and CMS-audit data.

Stratifications

- WISeR Item/Service (about 25% of included WISeR Items/Services per performance period)
- Prior authorization request or pre-payment review
- Affirmation/non-affirmation (for prior authorization requests) or approval/denial (for pre-payment reviews)

Risk Adjustment

None.

Improvement Notation

A higher percentage indicates better performance.

Definitions

Initial Prior Authorization Submission: A request by a WISeR Provider or WISeR Supplier for provisional affirmation for one of the select items and services prior to furnishing such items and services to the WISeR Beneficiary and before the claim is submitted for processing.

Expedited Submission: Prior authorization request from a WISeR Provider or Supplier and confirmed by a WISeR Participant that indicates that delays could jeopardize the life, health, or ability to regain maximum function of the WISeR Beneficiary. The WISeR Participant will communicate a determination within 2 calendar days of receipt of the expedited request.

Resubmission: Submissions within 120 calendar days of an initial prior authorization determination for a prior authorization previously submitted by the same WISeR Provider or WISeR Supplier for the same WISeR Beneficiary and for the same item or service. Resubmissions are counted as separate denominator events for this measure.

Pre-payment Review: A review by the WISeR Participant to verify consistency with Medicare Coverage Criteria for a claim for one or more select items and services furnished in the MAC Jurisdiction that is submitted for payment without requesting prior authorization.

Guidance

For reporting, resubmissions of initial determinations made during the performance period are included in the performance period in which the initial determination was made.

Services Selected for Audit:

- CMS audits about 25% of included WISeR services per PP for all WISeR Participants.
- In Q1-Q3, services are randomly selected from those not yet audited that calendar year.
- In Q4, CMS audits remaining services and re-audits services as needed to ensure equal number of audited services across quarters.

Record Categories:

CMS creates record categories, which are combinations of:

- WISeR Item/Service (about 25% of included services per PP).
- Review type (prior authorization or pre-payment review).
- Outcome (affirmation/approval or non-affirmation/denial).

For each of the selected services in a performance period, CMS audits four record categories:

- Prior authorization affirmations
- Prior authorization non-affirmations
- Pre-payment approvals
- Pre-payment denials

Handling Initial Submissions and Resubmissions:

For the purposes of sampling and audit, the unit of analysis is the chain rather than the individual determination. To maintain statistical independence required by the sampling methodology, determinations are grouped into chains. The 8/30 sampling methodology assumes that each sampled unit is independent, but an initial determination and its linked resubmission(s) are not independent since they are connected to the same coverage request. Chaining ensures the statistical validity of the sampling approach.

- Chain Definition: A chain consists of an initial submission and any associated resubmissions.
    - If there is only an initial determination with no resubmission within 120 days, the chain contains one determination.
    - If there are resubmissions, all related determinations form a single chain.

- Chain Sampling: Within each record category, CMS randomly selects 30 chains (rather than 30 individual determinations) for audit.
- Chain Accuracy Assessment:
    - Single-determination chains: The accuracy of the chain is determined by whether that single determination is consistent with Medicare coverage criteria.
    - Multi-determination chains: For each sampled chain, one determination is randomly selected as the record to be audited by CMS. The accuracy of the chain is determined by whether that randomly selected determination is consistent with Medicare coverage criteria.

Selecting Chains for Audit:

Within each record category, resubmissions are linked to their associated initial submissions to form chains using the following fields: Participant ID, Provider NPI, Beneficiary MBI, WISeR Service Category, and Add-on Code indicator. Records sharing the same values for these fields are sorted by determination date and linked into the same chain as long as the gap between consecutive determinations does not exceed 120 calendar days. A gap exceeding 120 days starts a new independent chain. Ordering the chains randomly, CMS requests documentation for all selected chains up front:

- If 40 or more chains are available in the record category: Using the randomly-ordered chains, select the first 30 chains per record category for audit, and select the next 10 additional chains to be reserved for oversampling
  or
- If there are fewer than 40 chains available in the record category, select all chains per record category

Each selected record is uniquely identified by the Record ID provided by the WISeR Participants. The oversample will be used in the case of data errors, whereas chains with inadequate documentation will be considered inaccurate.

8/30 Methodology for Audit:

For each record category, CMS reviews the chains to assess whether the WISeR Participant determination was consistent or inconsistent with Medicare coverage criteria.

- If there are 30 chains:
    - If the initial 8 chains are all accurate (i.e. consistent with Medicare coverage criteria), the audit is complete for that record category.
    - If any of the initial 8 are inaccurate, including documentation issues, CMS reviews the additional 22 chains (total 30).
- If there are 8-29 chains: CMS reviews the initial 8 chains. If any are inaccurate, all the remaining chains are reviewed.
- If there are fewer than 8 chains: CMS reviews all available chains.
- If there are 0 chains for a record category, it is excluded due to a zero weight in the formula calculation.

Record Category Scoring:

CMS assigns a separate accuracy rating for each record category based on Table 1. If documentation is missing or inadequate for a record to be audited, the record category automatically receives a "Low" rating and 0 points.

Table 1: WISeR Accuracy Benchmarks and Unweighted Points

Rating	Determinations Consistent with Original Medicare Coverage Criteria[2]	Unweighted Points*
High	90% - 100%	1.0
Medium	60% - 89%	0.5
Low	<60%	0.0

* Point allocations apply to WISeR-2 calculation under pay-for-performance (PP4 and later).

Rounding:

Accuracy percentages are rounded to the nearest whole number using standard rounding rules (0.5 rounds up) before applying performance thresholds. For example, an accuracy of 89.5% rounds to 90% and receives a High rating, while 89.4% rounds to 89% and receives a Medium rating.

Initial Population

All prior authorization and pre-payment review determinations (sampled as chains) issued by WISeR participants for WISeR items or services during the performance period and selected by CMS for audit.

Denominator Exclusions

Prior authorization request or pre-payment review that does not have a determination within the performance period.

Dismissed prior authorization request(s) or ineligible pre-payment review(s).

Denominator

All determinations (prior authorization and pre-payment review) selected by CMS for audit during the performance period.

[2] **Statistical Basis of Performance Thresholds:** The 60% and 90% accuracy thresholds are based on exact confidence intervals for the binomial distribution for a sample size of 30.
N = 8: With a sample size of 8, record categories that would be classified as "Medium" if 30 records were reviewed could possibly be categorized as "High" based on the initial review of 8 records alone.
N = 30: The additional precision necessary to distinguish between "High" and "Medium" levels of accuracy is achieved when the sample is expanded to 30 records. For details, see: https://wpcdn.ncqa.org/www-prod/wp-content/uploads/2018/07/20180110_830_Procedure.pdf

Numerator

All audited determinations in the denominator that are found by CMS to be consistent with the Medicare coverage criteria.

Steps:

1. For each determination in the denominator, review the CMS audit result.
2. Count the number of determinations that are found to be accurate.

Numerator count: Number of audited determinations that were consistent with the Medicare coverage criteria

The raw accuracy percentage for each record category is calculated as: Numerator / Denominator = Percentage of audited determinations that are accurate

Weighting and Scoring WISeR 2

This information applies to WISeR-2 scoring under pay-for-performance (effective for PP4 and later performance periods.)

After CMS assigns accuracy ratings (0, 0.5, or 1) to each record category, CMS calculates a weighted score.

Each record category is weighted proportionally based on its volume relative to all audited determinations.

- $Weight = Total\ Points\ Available \times \frac{\#Determinations\ Issued\ for\ Category}{\#Determinations\ Issued\ for\ all\ Audited\ Categories}$
- $Overall\ WISeR\ 2\ Score =$

  $\sum Unweighted\ \ Points \times \left(Total\ Points\ Available \times \frac{\#Records\ in\ Category}{\#Records\ in\ all\ Audited\ Categories}\right)$
- This ensures higher-volume categories have a greater influence on the final score.