

Wasteful and Inappropriate Service Reduction (WISeR) Model Term Definition Fact Sheet

Fact Sheet Overview



Select items and services covered under Original Medicare are subject to pre-payment review. The WISeR Model offers an additional pathway that enables beneficiaries, WISeR Providers, and WISeR Suppliers to know in advance whether an item or service is subject to prior authorization. This fact sheet provides **definitions and examples for common terms** used in the WISeR Model related to prior authorization and pre-payment review processes and determinations.

Prior Authorization-Related Term Definitions

WISeR Select Items or Services, defined in Appendix A of the [WISeR Provider and Supplier Operational Guide](#), are subject to prior authorization or pre-payment review under WISeR.

- **Provisional Affirmation:** When a prior authorization request for a WISeR Select Item or Service is accepted by the WISeR Participant as meeting the applicable Medicare coverage criteria. This means the WISeR Participant has enough information to review the request, the request is within the scope of WISeR, and the submitted information supports Medicare coverage of the requested item or service. Claims with an associated provisional affirmation will be paid in full so long as all applicable Medicare coverage and clinical documentation requirements are met. The claim must also be billed and submitted correctly.
- **Non-Affirmation:** When a prior authorization request for a WISeR Select Item or Service is not accepted by the WISeR Participant as meeting the applicable Medicare coverage criteria. This means the information submitted with the request does not support the applicable Medicare coverage criteria of the requested item or service. A non-affirmation may also result when the request contains technical errors or does not include sufficient information or clinical documentation to support a provisional affirmation.
- **Provisional Partial Affirmation:** When a prior authorization request with multiple CPT or HCPCS codes has one or more CPT or HCPCS codes for a WISeR Select Item or Service that meet provisional affirmation criteria, and one or more CPT or HCPCS codes that meet criteria for non-affirmation.
- **Resubmission:** A prior authorization request that is submitted to the WISeR Participant within 120 days of an initial prior authorization determination that was previously submitted by the same WISeR Provider or WISeR Supplier for the same WISeR Beneficiary and same Select Item or Service. When resubmitting a prior authorization request, the WISeR Provider or WISeR Supplier should use with the same UTN associated with the initial prior authorization request.
- **Dismissal:** When a WISeR Participant dismisses a prior authorization request because information required to process the request is incomplete or invalid, the request falls outside the scope of the WISeR Model, or the request is a duplicate. Dismissed requests are not reviewed for medical necessity. Common dismissal reasons are described in the table on the next page.

¹. Original Medicare beneficiaries are eligible for WISeR. WISeR Providers and WISeR Suppliers furnish at least one Select Item or Service to Original Medicare beneficiaries and submit claims to the MAC associated with a WISeR Participant in Arizona, New Jersey, Ohio, Oklahoma, Texas, or Washington. Eligible sites of service are Hospital Outpatient Department (type of bill 13X for facility claims, corresponding to POS 19 and 22 on professional claims), Ambulatory Surgery Center (POS 24), home (POS 12), and office (POS 11).

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Common Reasons for Dismissal of a Prior Authorization Request

Dismissal Reason	Additional Explanation
The prior authorization request is submitted to the incorrect WISeR Participant or Medicare Administrative Contractors (MAC)	Each state included in the WISeR Model test has a WISeR Participant and MAC associated with it.
The prior authorization request is not for a WISeR Select Item or Service.	Only WISeR Select Items or Services as defined in Appendix A of the WISeR Provider and Supplier Operational Guide are subject to prior authorization review under the WISeR Model. ²
The beneficiary has a Medicare Advantage Plan or Medicaid and is not dually eligible.	The WISeR Model applies to Medicare Fee-for-Service beneficiaries.
The prior authorization request contains an invalid, missing, or deceased Medicare Beneficiary Identifier (MBI) or beneficiary name.	WISeR Providers and WISeR Suppliers must include certain data elements in a prior authorization request to be processed.
The request has invalid or missing billing information (PTAN, NPI, or TOB code). ¹	WISeR Providers and WISeR Suppliers must include certain billing information in a prior authorization request to be processed.
The prior authorization request is submitted by an ineligible provider or supplier	The WISeR Model only applies to select WISeR Providers and WISeR Suppliers who meet the criteria described in the WISeR Quick Reference for Providers and Suppliers section of the WISeR Provider and Supplier Operational Guide .
The prior authorization request is submitted by a WISeR Provider or WISeR Supplier with exemption status.	WISeR Providers and WISeR Suppliers with exemption status do not need to submit prior authorization requests during the time period for which they hold exemption status.
The prior authorization request is a duplicate request.	A duplicate request is a new prior authorization request submitted by the same WISeR Provider or WISeR Supplier for an identical WISeR Beneficiary and Select Item or Service before a determination has been issued for any earlier prior authorization requests.

1. PTAN: Provider Transaction Access Number; NPI: National Provider Identifier; TOB: Type of Bill

2. For a subset of WISeR Select Items and Services, prior authorization and pre-payment review is limited to certain indications as specified in the NCDs, LCDs, and Medicare Coverage Criteria. The ICD-10 codes for these indications are in Appendix B of the [WISeR Provider and Supplier Operational Guide](#).

Pre-Payment Review-Related Term Definitions

- **Approval:** When a claim for a WISeR Select Item or Service undergoing pre-payment review **meets** the applicable Medicare coverage criteria.
- **Denial:** When a claim for a WISeR Select Item or Service undergoing pre-payment review **does not meet** the applicable Medicare coverage criteria.
- **Ineligible:** When a claim for an item or service undergoing pre-payment review is not a claim for one or more WISeR Select Items or Services and therefore does not fall within the scope of the WISeR Model.



Claims deemed ineligible for pre-payment review for WISeR will be released and processed by MACs like all other non-WISeR claims. If a MAC sends a claim to a WISeR Participant for pre-payment review, and the WISeR Participant deems the claim ineligible, the WISeR Participant will communicate the finding to the MAC, and the claim will be processed by the MAC.

Additional Resources

[WISeR Model Webpage](#) | [WISeR Provider and Supplier Operational Guide](#) | [FAQs](#)

Questions? WISeR@cms.hhs.gov