New CMS WISeR Model

This is Medicare's attempt to expand prior authorizations.

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The Centers for Medicare & Medicaid Services (CMS) is launching a new program, voluntary for providers, aimed at decreasing wasteful spending. Only providers in a small number of states will have the option to participate in this program and the program will only pertain to a limited number of service types. The program is scheduled to take effect January 1, 2026.

The Concern

Plans for this program were released through the Federal Register in Published Document 2025-12195 (90 FR 28749).[1] This is public information and is available online at no charge. This Federal Register entry begins by explaining that CMS data indicates that wasteful medical spending accounts for an estimated 25 percent of total healthcare spending in the United States.[2,3] This section explains that wasteful medical spending includes:

- Services that have little or no clinical benefit
- Services in which the risk of harm from the service outweighs its potential benefit
- Fraudulent billing practices
- Abusive billing practices

The Fix

CMS goes on to explain that this wasteful spending can be curbed, without much burden to providers, by instituting prior authorization that employs artificial intelligence and machine learning for certain services. CMS explains that prior authorization that employs artificial intelligence and machine learning can result in a significant decrease in wasteful spending with no adverse effect on quality of care or access to care while providing decisions that are "almost instantaneous."

WISeR

To trial prior authorization for certain services, CMS is launching its Wasteful and Inappropriate Service Reduction (WISeR) Model. This is voluntary for providers, is scheduled to take effect January 1, 2026, and is scheduled to be trialed for six years. Participation in the program will only be available to Medicare Part B providers in six states:

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

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Providers in other states will not have the option to participate. Providers in these six states will have the option to submit a request for prior authorization for only these 15 services:

1) Sacral Nerve Stimulation for Urinary Incontinence
2) Phrenic Nerve Stimulator
3) Electrical Nerve Stimulators
4) Deep Brain Stimulation for Essential Tremor and Parkinson's Disease
5) Vagus Nerve Stimulation

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6) Induced Lesions of Nerve Tracts

7) Epidural Steroid Injections for Pain Management excluding facet joint injections

8) Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

9) Cervical Fusion

10) Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee

11) Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea

12) Incontinence Control Devices

13) Diagnosis and Treatment of Impotence

14) Percutaneous Image-Guided Lumbar Decompression for Spinal Stenosis

15) Skin and Tissue Substitutes—(only applicable to states in MAC jurisdictions that have an active LCD for the skin substitute services in place).

Providers will not have the option to submit requests for prior authorization for any service that is not on that list.

Process

When a provider chooses to submit a request for prior authorization under this model, they will submit documentation that should support coverage of the service. After receipt of this documentation, the entity performing the review will be required to notify the applicant of their decision "within the timeframe specified by CMS." If a Medicare Part B provider in one of the six designated states performs one of the 15 services on the list, and chooses to not submit a prior authorization request, their claim will be subject to pre-payment medical review. CMS points out that this prior authorization model will have no impact on documentation requirements or coverage criteria.

How Can They Do This?

Section 1115A of the Social Security Act (the Act)[4] authorizes the Secretary to test innovative payment and service delivery models to reduce program expenditures. Because this is only a "model" and because this is being trialed for six years in only six states, this is considered a "test" of an innovative system that aims to reduce program expenditures.

Opposition

Several stakeholders have expressed opposition to this model. Among the provider groups voicing displeasure with this model is the American Podiatric Medical Association (APMA). Within days of the announcement of this program, the APMA responded to CMS with a robust letter voicing opposition. This letter was drafted with the input of APMA leaders, including members of the Board of Trustees, committee leaders, staff, and consultants. The full letter to CMS was shared by the APMA with its members after it was sent.

This letter begins by explaining APMA's opposition to any expansion of prior authorization within the Medicare program. The dangers of prior authorization were shared with references to literature that illustrates the cost and negative impact of prior authorization on patient care. APMA also took issue with CMS' plan of providing prior authorization results "within the timeframe specified by CMS" and explained the need for a much more specific timeline. This letter also requested a "gold carding" process, explaining that if this program must launch, CMS should offer benefits to those who consistently provide documentation that supports the medical necessity of the services they plan to perform.

A provider who consistently submits requests for prior authorization and consistently sees those requests granted should be exempt from the program on some level. One of the services on the list of 15 is skin substitute application. Skin substitute application is commonly performed by podiatrists for diabetic foot ulcers. With the plan of modeling artificial intelligence and machine learning that can process these prior authorization requests, if this model must commence, APMA requested that podiatrists performing skin substitute application for diabetic foot ulcers be involved in the construction of these models.

Conclusion

Starting January 1, 2026, Medicare Part B providers will have the option to submit prior authorization requests for certain services. Stakeholders, including the APMA, have voiced strong opposition to any expansion of prior authorization in the Medicare program. **PM**

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References

[1] https://www.federalregister.gov/documents/2025/07/01/2025-12195/medicare-program-implementation-of-prior-authorization-for-select-services-for-the-wasteful-and

[2] Speer M, McCullough JM, Fielding JE et al. Excess Medical Care Spending: The Categories, Magnitude, and Opportunity Costs of Wasteful Spending in the United States. Am J Public Health. 2020 Dec;110(12):1743-1748.

[3] Shrank WH, Rogstad TL & Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. JAMA. 2019;322(15):1501-1509.

[4] https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm

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