

# The WISeR Model: A Healthcare Provider's Operational Roadmap for Compliance, Risk Management, & Revenue Integrity

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# Executive Summary

Effective January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) will launch the Workforce in Surgical and Rehabilitative Services (WISeR) model, a six-year prior authorization and pre-payment review program designed to reduce fraud, waste, and abuse in Traditional Medicare. The model assigns 17 high-risk services across six geographic regions to private AI-powered “model participants” that will review medical necessity prior to or concurrent with payment [1].

For hospitals and suppliers in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington, this represents a fundamental shift in how they manage documentation, prior authorization workflows, and revenue cycle operations. Early analysis from the Office of Inspector General (OIG) suggests denial rates of 25% or higher for services like skin substitutes and neurostimulators—categories where fraud and abuse investigations have identified systemic documentation gaps and inappropriate billing patterns [2].

This white paper outlines the clinical, operational, and financial implications of WISeR and provides a comprehensive roadmap for hospital operators to prepare, comply, and mitigate revenue leakage. It addresses documentation standardization, interdepartmental governance, technology enablement, and the unique challenges posed by observation status and provider-liable inpatient downgrades in settings subject to WISeR review.

# 1. Background: The WISeR Model and Its Rationale

## 1.1 THE PROBLEM STATEMENT

Medicare fee-for-service (FFS) spending contains an estimated \$1.9 to \$5.8 billion in annual low-value or wasteful services [1]. Core vulnerabilities include:

- **Inadequate documentation** supporting medical necessity for high-cost interventions, particularly in pain management, wound care, and device implantation [2].
- **Misuse and overbilling of drugs and devices**, especially skin substitutes and neurostimulation devices, where provider incentives to maximize reimbursement have driven exponential cost growth [2].
- **Fragmented prior authorization systems** that vary by payer, resulting in inconsistent medical necessity review and delayed patient access to appropriate care [1].

The OIG's 2024 audit on skin substitutes is instructive: spending grew 640% in two years, reaching \$10 billion by 2024 (over 15% of all Part B drug spending), yet Part B (traditional Medicare) accounted for 93% of that volume while covering only ~48% of Medicare enrollees. Part B providers used higher quantities (82 vs. 69 units) and more expensive products (\$1,470 vs. \$730) than Medicare Advantage plans on the same patient cohorts, suggesting systemic overbilling and product selection bias [2].

Similarly, OIG audits of neurostimulator implants identified that more than 40% of sampled providers lacked sufficient documentation to support coverage requirements, particularly for mandatory psychological evaluation, multidisciplinary screening, and evidence of prior conservative therapy failure [2]. These compliance gaps created unallowable payments and patient safety risks.



## 1.2 THE WISeR SOLUTION

CMS will deploy AI-powered utilization management platforms operated by six private “model participants” to:

- **Standardize prior authorization processes** across Traditional Medicare in six states [1].
- **Review medical necessity** against National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) before or concurrent with payment [1].
- **Provide real-time feedback** on documentation gaps and submission quality, enabling providers to improve compliance and reduce post-service denials [1].

In exchange, model participants share in “averted costs”—a portion of savings generated by reducing inappropriate care—creating financial incentives aligned with detecting and preventing fraud and overutilization [1].

**Key operational fact:** This is not optional in WISeR states and for WISeR services. Hospitals cannot opt out; they can only choose whether to submit optional prior authorization (receiving a Unique Tracking Number, or UTN, if approved) or accept pre-payment medical review (claim held pending documentation request) [1].

## 2. WISeR Program Scope: Services, States, and Places of Service

### 2.1 GEOGRAPHIC COVERAGE

WISeR applies to providers and suppliers operating in six states:

▶ Arizona    ▶ New Jersey    ▶ Ohio    ▶ Oklahoma    ▶ Texas    ▶ Washington

**Critically, WISeR applies only to Traditional Medicare (outpatient services).** Medicare Advantage plans are not subject to WISeR review [1].

## 2.2 COVERED SERVICES

The model targets 17 high-risk service categories across surgical, rehabilitation, imaging, and device/supply domains [1]:

### Stimulation and Neurological Devices:

- Electrical nerve stimulation (peripheral, sacral, phrenic)
- Deep brain stimulation for essential tremor and Parkinson's disease
- Vagus nerve stimulation
- Hypoglossal nerve stimulation for obstructive sleep apnea

### Pain Management:

- Epidural steroid injections
- Induced lesions of nerve tracts

### Musculoskeletal Procedures:

- Percutaneous vertebral augmentation (kyphoplasty, vertebroplasty)
- Cervical fusion surgeries
- Arthroscopic lavage and debridement for knee osteoarthritis
- Percutaneous lumbar decompression for spinal stenosis

### Incontinence and Other:

- Incontinence control devices
- Diagnosis and treatment of erectile dysfunction

### Biologics and Substitutes:

- Skin and tissue substitutes  
(the focus of significant OIG fraud/abuse concerns) [2]

Each service has corresponding NCD and/or MAC-specific LCDs that define medical necessity, required diagnostics, prior conservative therapy thresholds, and documentation requirements [1].

## 2.3 PLACES OF SERVICE (CRITICAL FOR HOSPITAL OPERATIONS)

WISeR review applies across all settings where services are delivered to Traditional Medicare beneficiaries:

- **Hospital-based observation (bill type 13X) – Critical distinction** (addressed in Section 3).
- **Ambulatory surgery centers (ASCs, POS 24)** – Surgery and device implantation in free-standing facilities.
- **Physician office/supplier (non-facility, POS 11, 12)** – In-office injections, device fitting, consultations.

**Operational implication:** Hospitals must implement WISeR tracking across all revenue-generating sites, not just the main campus or surgery center. This includes decentralized wound care programs and affiliated physician offices that may perform WISeR services [1].

# 3. The Unique Challenge: Observation Status and Inpatient Downgrades (CC-44)

## 3.1 OBSERVATION PATIENTS UNDER WISER

A critical operational question for hospitals: **How does WISeR apply to observation status patients, and how will model participants handle downgrades?**

**The problem:** Observation is a hospital service status (not an admission level), meaning:

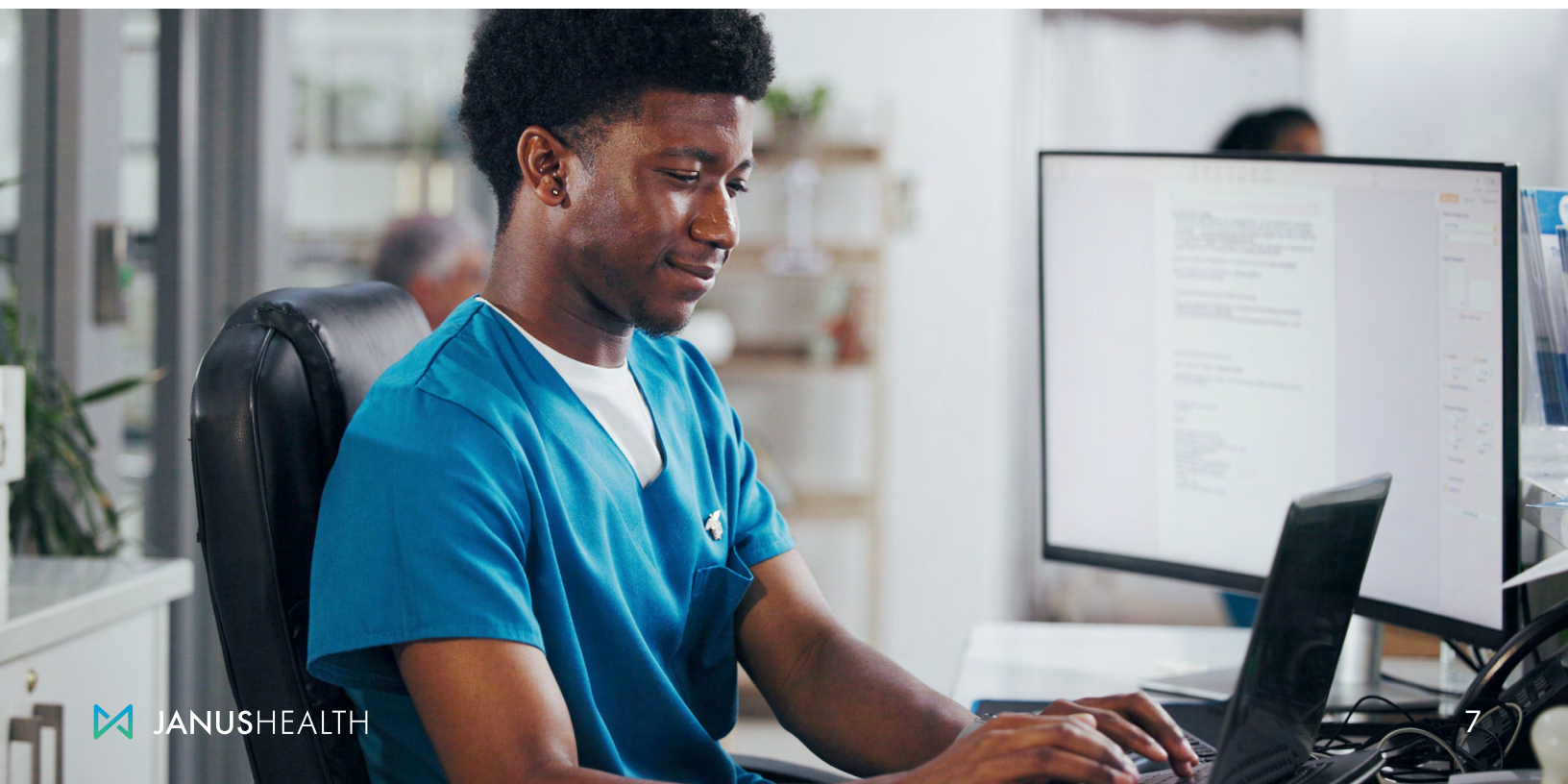
- Observation patient stays are billed as **bill type 13X (outpatient)**, not 11X (inpatient) [3].
- If an observation patient receives a WISeR service (e.g., skin substitute application during a wound care visit, neurostimulator trial or implant, etc), that service is subject to WISeR review [1].
- If UR downgrades an inpatient stay to observation while the patient is still inhouse, the final claim will typically be a 13X hospital outpatient bill, and WISeR does apply to the select services.
- If the stay is downgraded post discharge as part of a provider self-audit that claim is billed as a 121X bill type and not subject to WISeR requirements.

Given that WISeR model participants are AI systems focused on medical necessity of the service, not billing status, the safest operational assumption is that WISeR review applies to the service regardless of patient status to ensure that you have documentation to support medical necessity. Especially if you downgrade a lot of inpatient stays. [1]

## 3.2 RECOMMENDED HOSPITAL POLICY ON OBSERVATION AND DOWNGRADES [CC44]

Hospitals in WISeR states should establish clear guidance:

- 1. Upfront observation risk assessment:** Before admitting a patient for a WISeR service (especially high-risk ones like neurostimulator trials or complex wound care), clinical and RCM teams should jointly assess whether the admission criteria align with Two-Midnight Rule expectations and support inpatient status. Flag observation-likely cases early [1] [3].
- 2. Query model participants pre-service:** For complex cases (e.g., a patient with comorbidities requiring inpatient monitoring before proceeding with neurostimulator implant), hospitals may consider submitting an optional prior authorization request before admission that explicitly documents the expected length of stay and clinical justification [1]. This creates a paper trail and may anchor the service approval even if subsequent admission denials occur.
- 3. Dual WISeR tracking for 13X:** Implement separate tracking for WISeR services billed as observation (13X) vs. inpatient (11X) so that post-service audits can isolate the impact of downgrades.
- 4. Contingency for condition code 44 downgrades:** Budget and communicate to providers that admission downgrades on cases involving WISeR services may result in write-offs. This will affect provider professional claims as well. Establish dispute resolution and accountability processes [3].



# 4. Operational Playbook: Documentation, Workflows, and Compliance

## 4.1 WISER MODEL PARTICIPANTS AND THEIR STATE ASSIGNMENTS

CMS selected six AI-powered companies as model participants, each responsible for one or more WISer states [1]:

Model Participant	States	Platform/Focus
Cohere Health, Inc.	Texas	Clinical intelligence, utilization management
Genzeon Corporation	New Jersey	AI/automation (HIP One)
Humata Health, Inc.	Oklahoma	“Touchless” PA, EHR-connected AI
Innovaccer Inc.	Ohio	Flow Auth, end-to-end PA automation
Virtix Health LLC	Washington	Clinical data acquisition, coding validation
Zyter Inc. (Zyter TruCare)	Arizona	Population health, agentic AI for PA intake

Each participant operates a provider portal or esMD gateway where hospitals submit prior authorization requests and documentation [1]. Hospitals should immediately contact each participant (by state) to register, obtain portal credentials, and review submission requirements and timelines [1].

## 4.2 TWO PATHWAYS TO COMPLIANCE AND PAYMENT

CMS permits hospitals to choose a pathway for each WISeR service, case-by-case [1]:

### Pathway 1: Optional Prior Authorization (Recommended)

- **Timeline:** Submit to model participant or MAC via esMD, portal, mail, or fax.
- **Decision window:** 3 days for standard request; 2 days if marked expedited [1].
- **Outcome:** If approved, receive a Unique Tracking Number (UTN); UTN must accompany the claim for payment [1].
- **Claim impact:** Claims with valid UTN are subject to reduced pre-payment medical review scrutiny [1].
- **Risk:** Non-affirmation or request for additional documentation delays service delivery and introduces uncertainty [1].

### Pathway 2: No PA → Pre-payment Medical Review (Higher administrative burden)

- **Timeline:** Provide the service and submit claim without prior authorization [1].
- **Claim hold:** MAC holds claim pending WISeR participant review [1].
- **Documentation request:** WISeR participant requests medical records via ADR request [1].
- **Response window:** Hospital has 45 days to submit documentation; WISeR participant issues determination within 3 days of receiving all records [1].
- **Outcome:** Claim approved, denied, or partially approved [1].
- **Risk:** Extended A/R, cash flow delay, and potential retroactive adjustment if service deemed non-covered [1].

**Recommendation:** For high-risk services (skin substitutes, neurostimulators, epidural injections, vertebral augmentation) and complex cases, **default to Pathway 1 (optional PA)** to obtain UTN upfront. Use Pathway 2 if you must for low-risk, routine cases where documentation is robust and approval likelihood is high [1].

## 4.3 DOCUMENTATION EXCELLENCE: SERVICE-BY-SERVICE REQUIREMENTS

The OIG audits of skin substitutes and neurostimulators revealed systemic documentation gaps. Hospitals must train ordering providers to document to the exact language of the applicable NCD/LCD [2].

### A. NEUROSTIMULATORS (INCLUDING SACRAL NERVE, PHRENIC, DEEP BRAIN, HYPOGLOSSAL, VAGUS)

**OIG findings:** More than 40% of sampled providers lacked sufficient documentation [2].

**Required documentation elements (per NCD 160.7, 160.18, 160.19, 160.24, and MAC-specific LCDs) [2]:**

- **Failure of conservative therapy:** Document that non-operative treatments (e.g., physical therapy, medications, topical agents for pain; behavioral therapy for incontinence) were tried for a specified duration (often 3-6 months, varies by indication) and either failed, proved unsuitable, or were contraindicated. Include specific modalities and dates [2].
- **Multidisciplinary screening:** Document completion of a formal **multidisciplinary evaluation** involving at least two clinical disciplines (e.g., neurology, neurosurgery, physical medicine & rehabilitation, urology, psychology) [2]. Include screening dates and team sign-offs [2].
- **Psychological evaluation:** OIG flagged missing psychological/psychiatric evaluation in 34 of sampled cases. Document a formal psych eval (not just a casual note) addressing the patient's ability to manage the device, compliance potential, pain catastrophizing, depression, and suitability for implantation [2]. Include psych provider credentials and date of evaluation [2].
- **Temporary trial success:** For implantable neurostimulators, document successful response to a temporary electrode trial (percutaneous lead placement and stimulation for 3-7 days per NCD) with objective or subjective pain relief, improvement in function, or resolution of the target symptom (e.g., improved continence, reduced tremor) [2]. Include trial duration, stimulation parameters, and patient-reported outcomes [2].
- **Additional MAC-specific elements:** Check the relevant MAC LCD for your jurisdiction (Noridian, CGS, Novitas) for additional requirements on imaging, prior surgeries, or trial thresholds [1].

# DOCUMENTATION TEMPLATE FOR PHYSICIAN:

## NEUROSTIMULATOR EVALUATION SUMMARY

- Patient: [Name], DOB [date], MRN [ID]
- Indication: [Chronic pain / Sacral neuromodulation for urinary retention / etc.]
- Physician: [Name, credentials, specialty]
- Date of Note: [Date]

## CONSERVATIVE THERAPY FAILURE:

- PT/OT: [Type, dates, outcome—e.g., “6 months PT 2024, no improvement in pain”]
- Medications: [List trials, doses, dates, adverse effects]
- Other: [Specify]

All conservative modalities attempted from [start date] to [end date]. Conclusion: unsuitable/failed/contraindicated.

## MULTIDISCIPLINARY SCREENING:

- Neurosurgery: [Provider name, date, approval]
  - PM&R: [Provider name, date, findings]
  - [Additional specialty as per protocol]
- Team consensus: Candidate appropriate for stimulation trial.

## PSYCHOLOGICAL EVALUATION:

- Psychologist/Psychiatrist: [Name, credentials]
- Date: [Date]
- Clearance for implantation: [Yes/Qualified Yes/No]
- Key findings: [Note pain coping strategies, compliance capacity, suitability for device management]

## TEMPORARY TRIAL RESULTS:

- Trial duration: [Date to date, e.g., “3 days”]
- Lead placement: [Method, date, location]
- Stimulation parameters: [Frequency, amplitude, pulse width]
- Pain relief achieved: [% improvement, VAS before/after, or functional gains]
- Patient tolerance: [Good/acceptable/poor, note any complications]
- Recommendation: Proceed to permanent implant YES / NO

**PLAN:** [Permanent implant on date X or alternative]

## B. SKIN SUBSTITUTES (ALLOGRAFT, XENOGRAFT, SYNTHETIC)

OIG findings: \$10 billion spend in 2024, 640% growth in 2 years, systemic overbilling, suspicious billing patterns [2].

**Concerning patterns OIG identified** (hospitals should identify and flag internally) [2]:

- New providers (recent NPI) where >90% of all billing is skin substitutes with no wound care management.
- Multiple skin substitute claims on same DOS to circumvent \$99,999.99 claim rejection limits.
- Use for non-approved conditions (minor scrapes, blisters, cosmetic indications).
- Excessive quantities relative to wound size or total-body-like patterns.
- Use without prior conservative treatment.
- Specialty mismatch (e.g., neurologist, psychiatrist billing for wound care).

**Required documentation elements (per MAC LCDs L35041, L36690, and vendor WISeR guidance)** [1][2]:

- **Wound type and diagnosis:** Chronic diabetic foot ulcer (DFU), venous leg ulcer (VLU), chronic pressure injury, surgical wound, burn, or other covered indication. Document ICD-10 code, wound etiology, and duration (e.g., “DFU on left heel, present since [date], 8 weeks duration”) [1][2].
- **Prior conservative care:** Document at least 4 weeks of standard wound care (debridement, dressing changes, offloading for DFU, compression for VLU, etc.) **before** application of skin substitute. Include dates, dressing types, assessment of wound healing trajectory, and objective measurement showing lack of progress [1][2]. **This is critical;** OIG flagged cases where skin substitute was used at first visit without any conservative treatment attempt [2].
- **Wound measurement and photographic documentation:** Document wound dimensions (length, width, depth), estimate of % body surface area (BSA) involved, and clinical photographs if available [1]. This creates an objective record and prevents “total body” claims [2].
- **Quantity and product selection:** Document the **specific skin substitute product name and quantity (in square centimeters or units) applied**, the clinical reason for the product choice, and how it aligns with wound size [1]. Avoid vague entries like “applied multiple units” [2].

- **Frequency and frequency limits:** Document that frequency of application complies with MAC LCD limits (many LCDs restrict application to once per wound per day or similar) [1].
- **Specialty and provider credentials:** Ensure the ordering and applying providers have appropriate credentials for wound care (wound specialist, surgeon, dermatologist, etc.) and are not outside-of-scope specialties flagged by OIG [2].

## DOCUMENTATION TEMPLATE FOR WOUND CARE TEAM:

### SKIN SUBSTITUTE APPLICATION NOTE

- Patient: [Name], DOB [date], MRN [ID]
- Wound location: [Anatomical site]
- Wound diagnosis: [ICD-10 code, e.g., "L97.321 Non-pressure chronic ulcer of right lower leg, unspecified depth"]
- Wound duration: [Date of onset to present = X weeks/months]

### PRIOR CONSERVATIVE CARE (minimum 4 weeks):

- Standard wound care from [start date] to [present]:
  - » Cleansing/debridement: [Type, frequency, dates]
  - » Dressings: [Types used, e.g., "foam, alginate, silicone", dates]
  - » Offloading (if DFU): [Type, compliance]
  - » Compression (if VLU): [Type, class, compliance]
  - » Nutritional support: [If applicable]
- Wound assessment: [Baseline wound size, healing trajectory, % change if any]
- Outcome: [Wound improved / static / deteriorated]. Rationale for proceeding to skin substitute: [e.g., "No measurable healing after 6 weeks of standard care"]

### WOUND MEASUREMENT (at time of substitute application):

- Length: [X cm]
- Width: [X cm]
- Depth: [X cm]
- Area: [X cm<sup>2</sup>]
- % BSA: [X%]
- Drainage, odor, signs of infection: [Describe]

#### SKIN SUBSTITUTE APPLIED:

- Product name: [e.g., "GRAFTJACKET, APLIGRAF, INTEGRA"]
- Quantity: [X cm<sup>2</sup>, X units, or other]
- Date of application: [Date]
- Application method: [Sutured, stapled, overlaid, etc.]
- Clinical justification for product: [e.g., "APLIGRAF chosen for chronic VLU with heavy drainage; provides bi-layered construct and growth factors"]

#### COMPLIANCE WITH FREQUENCY LIMITS:

- Prior applications of this product to this wound: [None / describe]
- Frequency per MAC LCD: [Allowed X per [time period]]
- Current application complies: [Yes / specify deviation and clinical justification]

#### PROVIDER INFORMATION:

- Prescribing/ordering provider: [Name, credentials, NPI, specialty]
- Applying provider: [Name, credentials, NPI, specialty]
- Both have wound care expertise: [Yes / specify training]

**PLAN:** [Reassess wound healing at [X weeks], repeat substitute if indicated, or transition to standard care]

## 4.4 INTERDEPARTMENTAL COORDINATION AND TRAINING

### Clinical teams (MDs, advanced practitioners, nurses):

- Provide **templated smart phrases** for EHR entry aligned to NCD/LCD language.
- Conduct quarterly training on WISer service updates and denial patterns specific to your hospital.
- Establish peer-to-peer review with a designated "champion" provider who leads compliance culture [1].

### Utilization review and care management:

- Maintain **service-specific playbooks** with LCD/NCD text, medical necessity thresholds, and decision trees.
- For complex or borderline cases, route to a physician reviewer **before submission** to flag missing elements and reduce denials [1].
- Track approval rates by ordering provider to identify patterns and provide targeted re-education [1].

## Revenue cycle and coding:

- **Flag all WISeR CPTs** at registration, scheduling, and code assignment; trigger PA requirement workflows [1].
- Ensure **UTNs are captured, validated, and appended to claims**; implement front-end edits to prevent claims from dropping without valid UTN (if PA pathway selected) [1].
- Maintain **centralized tracking** of all prior authorization requests, UTNs, denials, and appeals [1].

## Compliance and medical records:

- Conduct **monthly audits** of WISeR service documentation using checklist templates to ensure completeness before submission [1].
- Respond to **WISeR participant documentation requests within 30 days** (even though the contract allows 45 days; faster response improves outcomes) [1].
- Track **post-service denials** and appeal outcomes; analyze root causes [1].

## 4.5 MAC AND MODEL PARTICIPANT ENGAGEMENT

### Immediate action items (by end of Q4 2025):

1. **Register on model participant portals** for your state(s) and obtain portal access.
2. **Contact each model participant** to request:
  - WISeR-specific submission requirements and documentation checklists.
  - Exact NCD/LCD interpretations they will use for medical necessity review.
  - Escalation and appeals processes.
  - Webinar/training schedules for providers and staff.
3. **Contact your MAC** (Noridian, CGS, Novitas, etc.) to:
  - Obtain updated LCD lists for WISeR services in your jurisdiction.
  - Register for MAC webinars on WISeR and prior authorization.
  - Clarify fallback processes if model participant is unavailable or unresponsive (claims may default to MAC for review).
4. **Review the CMS WISeR RFA PDF and provider guide** for authoritative guidance on timelines, appeals, and operational expectations [1].



## 5. Technology and AI: A Proactive Approach to Denial Prevention

### 5.1 THE CASE FOR AI-ASSISTED PRE-SUBMISSION REVIEW

**Current state:** Hospitals submit PA requests or claims with imperfect documentation. Model participants review, flag missing elements, request additional info, or deny. This cycle takes 3–45 days and incurs rework cost [1].

**Future state:** Implement internal AI systems that:

1. **Ingest the physician note, imaging, diagnostics, and prior visit history** from the EHR.
2. **Automatically parse against NCD/LCD criteria** (e.g., “Is there documented conservative therapy failure for  $\geq 6$  months?”, “Is there a psychology evaluation?”, “Is the wound  $\geq 4$  weeks old?”).
3. **Flag missing or non-compliant elements** and alert the care team or UR before PA submission [1].
4. **Route high-risk cases** to human reviewers (UR nurse, physician, case manager) for second look.
5. **Calculate likelihood of approval** and surface risk scores to enable informed decisions about pathway selection (Pathway 1 PA vs. Pathway 2 pre-payment review) [1].

**Expected benefit:** Reduce initial PA non-affirmations from (estimated) 15–25% to  $< 5\%$ , and reduce post-service denials by catching documentation gaps early. This also improves patient flow by preventing unnecessary delays [1].

## 5.2 RECOMMENDED TECHNOLOGY ARCHITECTURE

### Tier 1 (Immediate, Q1 2026):

- ▶ Implement **front-end EHR edits and alerting** for WISeR CPT codes:
  - » At order entry: “This CPT requires prior authorization. Documentation must include [checklist]. Click here for template.”
  - » At registration: “WISeR service detected. Is PA pathway chosen? Is UTN available?”
  - » At coding: “Prevent claim submission without valid UTN (if Pathway 1 chosen).”

### Tier 2 (Mid-term, Q2–Q3 2026):

- ▶ Deploy **rule-based AI/RPA** that reads clinical notes and compares against NCD/LCD criteria:
  - » Uses natural language processing (NLP) to extract clinical concepts (conservative therapy, trial duration, imaging findings, specialty evaluations).
  - » Applies deterministic rules (e.g., “IF no conservative therapy  $\geq$  6 months AND no psychology eval, THEN flag high-risk”).
  - » Routes flagged cases to human worklist or sends back to provider for addendum [1].

### Tier 3 (Long-term, Q4 2026 onward):

- ▶ Integrate with **model participant APIs** (if available) to:
  - » Submit PA requests directly via secure channel.
  - » Receive real-time determinations and UTN assignment.
  - » Trigger claim submission automatically upon approval.

### Vendor options:

- **Vendor Custom rule engines** built on healthcare data platforms (e.g., cloud-based, FHIR-compliant) may offer lower cost and higher customization for single-system deployments.

## 5.3 TRACKING AI-ASSISTED REVIEWS AND OVERTURNS

As AI reviews cases, hospital must track:

- **% of cases flagged by AI as high-risk** (missing documentation, non-compliant with LCD).
- **% of flagged cases overturned by human review** (clinician adds documentation or provides clinical justification for deviation).
- **Approval rate for AI-flagged vs. non-flagged cases** at PA submission stage.
- **Post-service denial rate for AI-flagged vs. non-flagged cases.**

**Hypothesis:** AI-flagged and human-reviewed cases should show higher approval and payment rates, validating the efficiency of pre-submission review.

# 6. Revenue Impact and Risk Mitigation

## 6.1 EXPECTED DENIAL RATES AND FINANCIAL EXPOSURE

### Historical baseline (OIG findings):

- **Neurostimulators:** >40% of providers non-compliant with documentation requirements; assume 15–25% initial denial rate, declining to 5–10% with improved documentation [2].
- **Skin substitutes:** OIG audit identified systemic overbilling, quantity excess, lack of conservative care, and specialty mismatch; assume 25–35% initial denial rate for facilities without robust controls, declining to 10–15% with strengthened protocols [2].
- **Epidural injections, vertebral augmentation:** Mid-tier risk; assume 10–20% denial rates pending specific LCD compliance [1].

Total exposure: For a large hospital with \$20–50M in annual Medicare FFS revenue, WISer-targeted services may represent 5–15% of that volume. Initial denial impact could be \$1–7.5M before mitigation [1][2].

## 6.2 MITIGATION STRATEGIES

### Documentation excellence (Highest ROI):

- Implement templates and checklists aligned to NCD/LCD.
- Conduct pre-submission AI/manual review.
- Expected impact: Reduce denial rate by 30–50% (e.g., from 25% to 12–17%).

### Prior authorization discipline (Pathway 1 default):

- Submit optional PA for all high-risk services; obtain UTN before service delivery.
- Expected impact: Reduce first-pass denial rate by 10–15% and improve cash flow predictability.

### Interdisciplinary governance:

- Establish WISer workgroup (clinical, UR, RCM, IT, compliance); meet monthly to review denials, trends, and corrective actions.
- Expected impact: Identify systemic issues (e.g., specific provider or specialty with high denials) and address quickly.



### Technology enablement:

- Implement AI-assisted pre-submission review and front-end claim edits.
- Expected impact: Accelerate compliance trajectory; reduce denial rate ramp-down from 12–18 months to 6–9 months.

### Appeals and recovery:

- Implement systematic appeals process for first-pass and post-service denials; track overturn rate.
- Expected impact: Recover 20–40% of initial denials through appeals.

## 6.3 FINANCIAL METRICS AND KPI DASHBOARD

### Hospital WISeR Scorecard (monthly tracking):

KPI	Target	Current	Trend
WISeR service volume (claims)	Baseline		
WISeR service revenue (gross)	Baseline		
Prior authorization affirmation rate	>90%		
Days from PA submission to determination	<5 days		
Post-service denial rate (WISeR services)	<10%		
Appeal overturn rate	>25%		
Days from initial denial to appeal resolution	<60 days		
Net payment rate (WISeR revenue / gross charges)	>85%		
AI-flagged cases (% of WISeR submissions)	Monitoring		
AI-flagged cases overturned by clinician (%)	Monitoring		

# 7. Gold Card and Long-Term Compliance

## 7.1 GOLD CARD ELIGIBILITY CRITERIA

CMS and WISeR model participants are expected to offer “gold card”-type exemptions—conditional relief from some prior authorization requirements—for providers with sustained high compliance and approval rates [1].

### Preliminary criteria (not yet formally published by CMS):

- **Prior authorization affirmation rate  $\geq$ 95%** over a sustained period (e.g., 6–12 months) [1].
- **Submission accuracy and completeness** as measured by low request-for-additional-documentation rates.
- **No patterns of fraud, abuse, or policy violation** based on post-service audits.

**Expected timeline for gold carding:** Likely Q3–Q4 2026 for early performers; broader rollout in 2027 [1].



## 7.2 STRATEGIC POSITIONING FOR GOLD CARD

To position for gold card status:

- **Establish clear accountability** at the provider (individual MD) and department (surgery, wound care, PM&R) level for approval rates.
- **Track metrics monthly** and provide feedback to providers; celebrate high performers and remediate low performers.
- **Implement continuous improvement:** After each quarter, analyze denials, refine templates, and retrain teams.
- **Maintain robust documentation** even for seemingly routine cases; don't cut corners as approval rates climb.
- **Engage with model participants:** Proactively communicate with them, ask for feedback, and signal commitment to compliance [1].

# 8. Implementation Timeline and Governance

## 8.1 CRITICAL DATES

Date	Milestone
Dec 19, 2025	Model participant announcements (completed)
Jan 1, 2026	WISeR model launch
Jan 5, 2026	First date to submit optional prior authorization requests
Jan 15, 2026	First date services can be performed under WISeR
Jan–Feb 2026	Early operational learning; expect high volume of requests and educational back-and-forth with model participants
Mar–Jun 2026	Refinement phase; adjust templates, workflows, and staff based on early outcomes
Jul–Dec 2026	Maturation; aim for 90%+ approval rates and <10% post-service denial rates
Q3–Q4 2026	Gold card discussions and early eligibility announcements

## 8.2 GOVERNANCE STRUCTURE

### WISeR Executive Sponsor

Chief Medical Officer, Chief Revenue Officer, or Chief Financial Officer. Owns strategy, resource allocation, and board reporting.

### WISeR Operations Workgroup (monthly)

- Chief Medical Officer or designee (clinical leadership)
- Director of Utilization Review/Case Management
- VP of Revenue Cycle/Patient Financial Services
- IT/EHR systems owner
- Compliance/Audit officer
- Physician champion(s) for high-impact service lines (neurosurgery, wound care, pain management)

### Responsibilities:

- Monitor KPIs, denial trends, and provider compliance.
- Review WISeR updates from CMS and model participants.
- Identify systemic issues and approve corrective actions.
- Communicate progress to executive leadership and clinical staff.

### Provider Education Taskforce

- Responsible for developing and rolling out training for MDs, NPs, PAs, nurses, and coding/billing staff.
- Quarterly refresher training; ad hoc sessions following high-denial cases.

# 9. Critical Risk Factors and Mitigation

## 9.1 MODEL PARTICIPANT CONFLICTS OF INTEREST

**Risk:** WISeR model participants are paid a portion of averted costs (reduced spending), creating financial incentive to deny or request additional documentation beyond what is clinically necessary [1]. Additionally, several participants have ties to health insurers and venture capital firms affiliated with payers, raising concerns about conflicted incentives [1].

### Mitigation:

- **Maintain appeals discipline:** Don't accept first non-affirmation; appeal substantively for clinically appropriate cases.
- **Engage peer-to-peer reviews:** Request discussions with model participant physician reviewers to discuss clinical disagreements.
- **Document everything:** Ensure medical records are bulletproof so that even if a case is denied at PA stage, it can be recovered on appeal.
- **Track model participant behavior:** Monitor approval rates and decision patterns by participant and state; escalate concerning trends to CMS and your state's Congressional delegation if appropriate.

## 9.2 INADEQUATE HOSPITAL INFRASTRUCTURE

**Risk:** Hospitals without robust EHR systems, centralized prior authorization platforms, or UR expertise may struggle to implement WISeR workflows, leading to high error rates and denials [1].

### Mitigation:

- **Invest in technology early:** Prioritize EHR updates, workflow configuration, and AI/RPA tools before January 2026 launch.
- **Hire or contract expertise:** Consider temporary staffing or consulting support to ramp up prior authorization and coding expertise.
- **Partner with third-party administrators (TPAs):** Some healthcare consulting firms offer WISeR implementation and ongoing management services.

## 9.3 PROVIDER RESISTANCE AND TRAINING FATIGUE

**Risk:** Physicians may resist new documentation requirements or perceive WISeR as administrative burden, leading to incomplete/substandard notes and complaints [1].

**Mitigation:**

- **Leadership alignment:** Ensure CMO and prominent clinicians publicly endorse WISeR compliance and benefits (protecting revenue, improving outcomes).
- **Make it easy:** Provide ready-to-use templates, smart phrases, and AI-assisted documentation tools so compliance doesn't feel burdensome.
- **Positive reinforcement:** Share approval rates and payment outcomes by provider; celebrate high performers.

**Peer leadership:** Engage respected physician champions to educate peers.

## 9.4 OBSERVATION STATUS AND INPATIENT DOWNGRADES

**Risk:** CMS has not clarified how downgrades from inpatient (11X) to observation (13X) interact with WISeR prior authorizations obtained under inpatient assumptions [1] [3].

**Mitigation:**

- **Implement observation risk screening** at admission; flag cases where WISeR service is planned and admission criteria may be questioned.
- **Submit pre-service PA** even for inpatient cases involving complex WISeR services, explicitly documenting expected LOS and admission justification.
- **Engage MACs and model participants** in writing about observation/downgrade scenarios; request clarification on how to handle 13X resubmissions.

# 10. Conclusion

The WISeR model represents a significant operational shift for hospitals in six states, particularly those with high volumes of high-scrutiny services like neurostimulators and skin substitutes. While the model's goal of reducing fraud and waste is clinically sound, hospitals must prepare rigorously to mitigate financial and operational risk.

## Key success factors:

1. **Documentation excellence aligned to NCD/LCD:** This is non-negotiable and has the highest ROI.
2. **Proactive prior authorization strategy:** Default to Pathway 1 (optional PA with UTN) for all listed services.
3. **Technology enablement:** AI-assisted pre-submission review prevents avoidable denials.
4. **Interdisciplinary governance:** Clinical, UR, RCM, IT, and compliance teams working together.
5. **Provider engagement and continuous improvement:** Providers are the front line; education, feedback, and accountability are essential.
6. **Appeals discipline:** Don't accept first denials for clinically appropriate cases.

**Timeline:** Hospitals have 2 weeks to prepare before the WISeR model launches on January 1, 2026. Organizations that move quickly on templates, training, workflow configuration, and vendor engagement will see faster compliance trajectories and higher approval rates. Those that delay risk significant revenue leakage and compliance exposure [1].

The six model participants and their state assignments are now public. **Contact them immediately** to register, understand their submission platforms and requirements, and begin operational readiness activities.

# References

[1] Centers for Medicare & Medicaid Services (CMS). (2025). *Workforce in Surgical and Rehabilitative Services (WISeR) model*. CMS Innovation Center. <https://www.cms.gov/priorities/innovation/innovation-models/wiser>

[2] Office of Inspector General (OIG). (2024). *Audit reports on skin substitutes and neurostimulator billing*. Department of Health & Human Services. [Internal findings cited in this white paper; detailed reports available at <https://oig.hhs.gov/>]

[3] Centers for Medicare & Medicaid Services (CMS). (2022). *Two-Midnight Rule and observation status*. CMS guidance for hospital admission status determinations.

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**For:** Hospital operators, Chief Medical Officers,  
Chief Revenue Officers, Revenue Cycle leadership

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