

WISeR Model Education Sheet



OHIO
FOOT AND ANKLE
MEDICAL ASSOCIATION

Overview

The **Wasteful and Inappropriate Service Reduction (WISeR) Model** is a Centers for Medicare & Medicaid Services (CMS) initiative that introduces prior authorization for select outpatient services in traditional fee-for-service Medicare. The goal is to reduce unnecessary utilization while maintaining timely access to medically necessary care.

Providers have a choice: they can submit a prior authorization request before providing an eligible service or opt out and have their claim subject to pre-payment medical review.

This education sheet provides an overview of the WISeR Model as it applies to Ohio podiatrists. It is intended for educational purposes and does not include every operational detail or scenario.

Podiatry Services Impacted

Procedure

- Wound Application of Cellular and/or Tissue-Based Products (CTPs), Lower Extremities (LCD L36690)

Sites of Service

- Hospital Outpatient Department (POS 19, 22)
- Ambulatory Surgery Center (POS 24)
- Office (POS 11)
- Home (POS 12)

Important Notes

- There is no change to Medicare coverage criteria
- There is no change to documentation requirements
- Existing National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) still apply

Key Takeaways

- WISeR does not change coverage rules – only the review process
- Submitting prior authorization proactively may reduce payment delays
- Innovaccer Inc. (the vendor assisting CGS implement WISeR in OH) has a [WISeR overview page](#).
- OHFAMA continues to monitor implementation and advocate for Ohio podiatrists
- For updates, resources, and advocacy efforts related to the WISeR Model, please stay engaged with OHFAMA and APMA communications.
- [APMA has developed a resource page](#) to use as a homebase

About OHFAMA Advocacy

Through ongoing advocacy, OHFAMA and APMA work to reduce administrative burden, protect access to care, support fair reimbursement, and ensure podiatrists can continue practicing to their full legal scope of practice, education, and training. Member involvement and support allow OHFAMA to effectively advocate for the profession during implementation and beyond.

OHFAMA encourages members to notify the association of any issues, concerns, or disruptions they experience with WISeR.

The Ohio Foot and Ankle Medical Association is the unified voice for podiatric physicians in Ohio. OHFAMA advocates for policies that protect patient access, support fair reimbursement, reduce unnecessary administrative burden, and allow podiatrists to practice to the full scope of their education and training.

Step 1: Prepare Documentation

1. Gather documentation: Medical records and other required documentation to support the medical necessity of the service. Refer to the WISeR Provider and Supplier Operational Guide for documentation requirements.
2. Following existing Medicare coverage policies
 - National Coverage Determinations/NCDs
 - Local Coverage Determinations/LCDs

Step 2: Choose your Pathway

For WISeR-identified services, Ohio podiatrists may choose one of two pathways:

Option A: Do NOT Submit a Prior Authorization Request

- Claim will be subject to pre-payment medical review
- Provider will receive a request for documentation
- 45 days to submit requested documentation
- Determination issued within 3 days of receipt
- Appeal rights remain unchanged

Option B: Submit a Prior Authorization Request through:

- [Innovaccer WISeR Provider Portal](#)
- [CGS](#) (will forward your information to Innovaccer)

Step 3: How to Submit

All prior authorization requests for WISeR must be submitted with the [PAR 457 form](#).

Submitting through CGS

- [myCGSPortal](#)
- Fax: 615-660-5300
- Mail: CGS Administrators, LLC J15 Part B
Correspondence PO Box 20018 Nashville, TN 37202.

Submitting Directly to Innovaccer

- [Innovaccer WISeR Provider Portal](#)
- [Electronic Submission of Medical Documentation \(esMD\)](#)
- Fax : 419-965-6730

If you submit through CGS, CGS will forward your information to Innovaccer. Innovaccer will review the request and send CGS, the provider/supplier, and the beneficiary a decision letter with an associated Unique Tracking Number (UTN). Prior authorization decisions and associated UTNs are valid for 120 calendar days from the decision date.

Step 4: Determination and Timeframes

Review Time frames

- **Standard Review:** Decision issued within 3 calendar days of receiving required documentation
- **Expedited Review:** Decision issued within 2 calendar days if patient health is at risk
- CMS may also issue a dismissal (for incomplete/invalid or out-of-scope requests) and, effective April 1, 2026, may issue a provisional partial affirmation for one or more services on the prior authorization request.

If Affirmed

- Determination returned via the same submission method
- Includes a Unique Tracking Number (UTN)
- UTN must be included on the claim form
- Authorization and UTN valid for 120 calendar days

If Not Affirmed

- Determination reviewed by human clinicians with relevant expertise

Providers may:

- Resubmit additional information
- Include the UTN from the non-affirmation
- Resubmit an unlimited number of times
- Request a peer-to-peer clinical review