August 29, 2025

SUBMITTED ELECTRONICALLY

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Coalition to Preserve Rehabilitation Concerns Regarding the WISeR Model and Access to Medically Necessary Rehabilitation Care

Dear Administrator Oz:

On behalf of the undersigned members of the Coalition to Preserve Rehabilitation ("CPR"), we write to express our serious concerns regarding the recently announced Wasteful and Inappropriate Service Reduction ("WISeR") Model, scheduled to begin on January 1, 2026. While CPR fully supports efforts to reduce waste, fraud, and abuse in the Medicare program, we are deeply troubled by the potential unintended consequences of the WISeR Model and curbing access to medically necessary medical rehabilitation and therapy services for beneficiaries with disabilities and other chronic conditions.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. CPR is comprised of organizations that represent patients—as well as the providers who serve them—who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

The WISeR Model introduces to the Medicare fee-for-service program a technology-driven, artificial intelligence-fueled, model to review the medical necessity of certain services. It relies on a financially-incentivized prior authorization and pre-payment review framework—much like the Recovery Audit Contractor ("RAC") program—for select items and services furnished under traditional Medicare in six states. The program takes the form of a five-year demonstration project but the impact of the program is much more pervasive and, potentially, permanent. The application of these elements of a demonstration model to traditional Medicare is unprecedented and, alarmingly, was announced with no opportunity for public comment. Worse yet, the model is expected to go into effect in less than six months.

CPR is particularly concerned that the model includes several categories of services—such as electrical stimulation, vertebral augmentation, cervical fusion, epidural steroid injections, and skin substitute applications—that are often medically necessary for individuals with disabilities and to enable patient participation in rehabilitation therapy. Delays or denials of these services, particularly under the traditional Medicare program, risk undermining patient recovery, functional progress, and long-term outcomes.

The financial structure of this model—where Medicare contractors keep a percentage of the reimbursements they recoup from Medicare providers—has been widely criticized under the Recovery Audit Contractor ("RAC") program and has led to disastrous results in Medicare auditing, particularly of inpatient rehabilitation hospital providers. Participants in WISeR are not providers or suppliers, but entities compensated based on a percentage of the cost savings generated through non-affirmation of claims—that is, denied claims that are not overturned after additional documentation is submitted. This financial structure creates a powerful incentive for contractors to deny coverage, rather than to promote accurate and objective determinations of medical necessity.

While the Center for Medicare and Medicaid Innovation ("Innovation Center") states that non-affirmations must be reviewed by licensed clinicians using evidence-based protocols, the model does not provide adequate details regarding the qualifications of these clinicians or how their expertise will be matched to specific services. For medical rehabilitation-related services, which often involve complex clinical decision-making and interdisciplinary coordination, it is essential that reviewers have deep familiarity with physical medicine and rehabilitation in order to ensure appropriate determinations. These same factors are in play with outpatient therapy services as well as physician-provided physical medicine and rehabilitation and pain management services.

CMS highlights the potential of artificial intelligence and machine learning to streamline prior authorization, as if prior authorization is well established in the fee-for-service program. But this program is a major expansion of prior authorization, which to date has been confined largely to the Medicare Advantage program and small-scale programs within the fee-for-service side of the program such as the Inpatient Rehabilitation Facility Review Choice Demonstration, the Home Health Review Choice Demonstration, and certain types of durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS").

Increased use of automation in coverage determinations through a prior authorization framework seriously undermines individualized clinical judgment. For people living with disabilities and complex medical conditions, rehabilitation care plans are rarely standardized. The misuse of algorithms in this context risks generating claim denials that may not be medically appropriate. In these instances, the burden will shift to patients and providers to gain access to patient care, only by struggling with the burdensome and time-consuming Medicare appeals process.

Furthermore, the WISeR Model also lacks adequate transparency and oversight. Model participants are not required to publicly report performance data, and providers and suppliers will not have access to key information—such as denial rates, appeal reversal rates, turnaround times for decision-making, or clinician reviewer qualifications—that would allow them to monitor

patterns of inappropriate denials or advocate for systemic improvements. Without access to such data, and with no formal avenue for stakeholder feedback, it will be difficult for CMS to evaluate the model's impact on patient access or correct unintended consequences in a timely manner.

Although the model is currently limited to six states—New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington—the Innovation Center has already indicated that it may expand the model to additional jurisdictions and service categories in future years. Before such expansion is considered, it is imperative that CMS fully assess whether the WISeR Model supports or hinders access to timely, medically necessary care. In its current form, the model raises significant concerns about both the alignment of financial incentives and the sufficiency of patient protections. The same concern exists for the potential of CMS to expand the list of services to which the WISeR applies. With no public comment and seemingly no constraints that CMS feels to solicit public input on this program, the likelihood is high that CMS will expand this program in the future to whatever services it wishes to subject to AI-based, financially-incentivized prior authorization.

CPR strongly urges CMS to reconsider the structure and implementation of the WISeR Model. At a minimum, we recommend that CMS delay implementation of this program and seek robust public input to ensure that any program that seeks to monitor medical necessity of traditional Medicare services puts patient access first. CMS must clearly define the clinical qualifications required of reviewers of all services included in this program, especially medical rehabilitation services, ensure meaningful public reporting and transparency, revise the participant payment methodology to prioritize patient outcomes over financial incentives to deny access, and establish stakeholder engagement mechanisms to inform ongoing oversight. Absent these and other meaningful changes to this program, the WISeR model threatens to disrupt access to care for patients who rely on key Medicare services, including medical rehabilitation services and therapies to restore Medicare beneficiary's health, function, and maintain independence.

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We appreciate your attention to these concerns and your commitment to ensuring that all Medicare beneficiaries have access to timely, high-quality medical rehabilitation and therapy services. CPR stands ready to work with CMS and the Innovation Center to ensure that future demonstration models support both program integrity and patient access. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ADVION
ALS Association
American Academy of Physical Medicine & Rehabilitation
American Association on Health and Disability

American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Child Neurology Foundation
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers (NASW)
National Disability Rights Network (NDRN)
National Multiple Sclerosis Society*
RESNA
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

**** CPR Steering Committee Member***

CC:

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