Medicare WISeR Pilot fact sheet and frequently asked questions
Treatment for impotence

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Overview of the Medicare WISeR Pilot

What is the Medicare WISeR Pilot?

WISeR stands for the Wasteful and Inappropriate Service Reduction (WISeR). It is a six-year, six-state pilot program aimed to reduce waste, fraud and abuse in the Medicare system. The Medicare WISeR Pilot aims to review **15 coverage categories** (reference **Federal Register**) which includes erectile dysfunction/impotence.

The Centers for Medicare and Medicaid Services (CMS) states that the program aims to utilize both Artificial Intelligence (AI) and Machine Learning (ML).

Is this program mandatory?

Obtaining the prior authorization prior to the patient receiving treatment is not mandatory, but if the authorization is not completed ahead of time, the claim will hold for a post audit review. Your office/facility will receive an Additional Documentation Request (ADR) and you will be required to send in supporting documents prior to receiving payment.

Which states are involved in the Medicare WISeR Pilot?

Providers in the following states are impacted by the Medicare WISeR Pilot:

• Arizona • New Jersey • Ohio • Oklahoma • Texas • Washington

If your practice is not located in one of these states, the process for seeking Medicare reimbursement for these procedures is not changing.

What is the purpose of the Medicare WISeR Pilot?

The goal of the Medicare WISeR Pilot is to reduce wasteful, inappropriate and unnecessary treatments which can cause harm and/or other adverse effects for patients.

How long will the Medicare WISeR Pilot run?

The Medicare WISeR Pilot started January 1, 2026 and runs through December 31, 2031.

Will this change Medicare coverage?

The WISeR Pilot will not change coverage for your patients who are being treated for impotence/sexual dysfunction, but the process for seeking reimbursement will change in the six states listed above.[1]

Will there be specific documentation requirements with the Medicare WISeR Pilot?

Since the Medicare WISeR Pilot is utilizing machine learning and artificial intelligence to process these prior authorizations, the WISeR Pilot may change how you document your visits. The Medicare WISeR Pilot will initially implement prior authorization for the insertion of penile prostheses (CPT codes 54400, 54401, and 54405). The specific documentation requirements identified by the WISeR program for ED patients per the **Provider/Supplier Guide** are:[2]

- Documentation of evaluation and diagnosis of erectile dysfunction (e.g., include testosterone level if a patient has signs or symptoms concerning for hypogonadism)
- Absence of systemic infection, active urogenital infection and/or active skin infection in the region of surgery
- Treatments tried and failed (or contraindicated), such as but not limited to addressing reversible etiologies:
  a) Oral medications, e.g., phosphodiesterase-5 (PDE-5) inhibitors
  b) Intracavernosal injection
  c) Vacuum-assisted erection device
  d) Psychotherapy (for psychogenic erectile dysfunction)
  e) Testosterone replacement therapy (for patients with testosterone deficiency)

Prior authorization requirements

The program is set up as voluntary prior authorization. However, if you do not participate in the prior authorization program prior to the surgery, the Medicare Administrative Contractor (MAC) will do a post-service review on the claim and may withhold payment without appropriate documentation from you.

Completing a prior authorization request

How do I submit a prior authorization request?

How you submit a prior authorization request will depend on your MAC and the state in which your practice resides.

Medicare providers can either directly submit their authorization request to the Model Participant (CMS-selected vendor for this pilot), or can submit directly to the MAC.

The MAC will forward the authorization to the selected Model Participant within 1 business day.

Submission of the prior authorizations can be completed many ways:

- Fax
- Mail
- Electronic portal
- Electronic submission of medical records through esMD

What information needs to be submitted with the authorization request?

The following information must always be included with the authorization request:

- Medicare patient name
- Diagnosis (ICD-10)
- Procedure (CPT) codes
- Facility name/location and requesting provider

How long will a prior authorization determination take?

Please allow for up to two weeks (ten business days) at the start of this program for your patient's authorization request to be approved.

The Medicare WISeR Pilot started on 1/1/2026 and the first day to submit a prior authorization request was on Monday, 1/5/2026. The Medicare WiSeR Pilot estimates that the earliest date a prior authorization would have been approved was 1/15/2026.

The program is aiming to complete a determination for standard review within three days of receiving your request. An expedited request is expected to be completed within two days of receipt.

If you plan to schedule a Medicare patient for implant surgery, you should schedule it later in January to allow enough time for the authorization to process. It is expected that moving forward, the prior authorization review timeline is approximately three days from receipt.

How long does a prior authorization approval last?

Approvals will be effective for four months (120 days) from the approval date.

What happens if my prior authorization request is denied?

You may resubmit another prior authorization request with additional supporting medical information (no limit)*, **or** you may request a peer-to-peer review, **or** you can follow the standard Medicare appeals process.

**to resubmit, include patient name, DOB and original denied unique tracking number (UTN)*

If I cannot schedule the patient for surgery within four months, can we get an authorization extension?

If you cannot schedule the patient for surgery within those 120 days, a new authorization would need to be completed. The program is not currently allowing for extensions.

If my patient is approved for the surgery, is there anything else I need to do?

Just like with commercial payers, you will be given an approval identification called a UTN.
When the claim is submitted to Medicare, both the provider claim and the facility claim should include this UTN.

Who are the selected contractors processing prior authorization requests?

State	MAC	Jurisdiction	Prior Authorization Request (PAR) Contact Center	NCD	Model Participant/ Vendor
Arizona	Noridian	JF	PAR	Diagnosis and Treatment of Impotence	Zyter
New Jersey	Novitas	JL	PAR		Genzeon Corporation
Ohio	CGS	J15	PAR		Innovaccer
Oklahoma	Novitas	JH	PAR		Humata Health
Texas	Novitas	JH	PAR		Cohere Health
Washington	Noridian	JF	PAR		Virtix Health

If you send the authorization request to your MAC, they will forward it to the proper vendor within one day.
Or you can submit directly to the vendor listed above for your MAC.

What documentation will I need to submit a prior authorization request?

While there are no specific guidelines on documentation/coding in the Treatment of Impotence NCD, the Medicare WISeR Pilot provider/supplier guide has published the following coverage/documentation guidance below. The Medicare WISeR Pilot will initially implement prior authorization for the insertion of penile prostheses (CPT codes 54400, 54401, and 54405). The specific documentation requirements identified for your ED patients per the **Provider/Supplier Guide** are:

- Documentation of evaluation and diagnosis of erectile dysfunction (e.g., include testosterone level if a patient has signs or symptoms concerning for hypogonadism)
- Treatments tried and failed (or contraindicated), such as but not limited to addressing reversible etiologies:
  a) Oral medications, e.g., phosphodiesterase-5 (PDE-5) inhibitors
  b) Intracavernosal injection
  c) Vacuum-assisted erection device
  d) Psychotherapy (for psychogenic erectile dysfunction)
  e) Testosterone replacement therapy (for patients with testosterone deficiency)
- Absence of systemic infection, active urogenital infection and/or active skin infection in the region of surgery

Submission of claims and adjudication

Once Medicare has approved coverage for the IPP procedure, you will be given a 14-digit UTN (also known as an authorization number) number. Make sure that this number is listed on your claim submission. On a paper claim, it would be in box 23.

Since most providers are billing electronically, please see below for some basic guidance on where the UTN should be listed in your billing **software**.

Physician billing

*Box 23 (of CMS 1500) maps to the **REF segment** in the **2300 Claim Information Loop**, with the REF01 element indicating the type of identifier and REF02 containing the number **itself**.*

Sample mapping may look like:

```
Claim information (2300)
REF*G1*12345678901234~
```

Hospital/ASC Billing

The following chart provides a crosswalk for several blocks on the 1450 (UB-04) paper claim form and the equivalent electronic data in the ANSI ASC X12N format, version 5010. The blocks listed are the blocks required for electronic claims. Any blocks that are not listed are not needed on the electronic claim.

Block	Field description	Loops	Segments	Qualifiers	Electronic description
63	Treatment authorization codes	2300	REF	G1	Treatment authorization codes

If you have further questions about including the UTN on the electronic claim form, please check with either with your MAC or software vendor.

If you obtained prior authorization and forgot to include the UTN on the claim – it will be routed for pre-payment claim review.[3]

Frequently asked questions

When will the Medicare WISeR Pilot portals be operational?

CMS worked closely with the Medicare WISeR Pilot participants to implement their portals by 1/5/2026 and test for readiness.

If the portals are not ready, is there another way for the provider to submit a prior authorization?

Providers can still submit prior authorization requests through the Medicare Administrative Contractor (MAC) if you encounter any issue with the model participant in your state.

Does the Medicare WISeR Pilot apply to all Medicare covered services?

No, this program applies **only** to these **15 coverage categories**.

What is the 'gold-card' program?

CMS is considering exempting certain providers who meet 90% approval rate for their authorizations within the provisional period. It is unclear of this provisional period is the entire pilot or a shorter timeframe.

Common coding guidelines

Coloplast provides general coding guidance for procedures utilizing our Men's Health devices. You can find our common codes here:

Physician Coding Guidelines

HOPD and ASC Coding Guidelines

Glossary

WISeR – The Medicare Wasteful and Inappropriate Service Reduction Pilot which aims to reduce wasteful and unnecessary treatments for your patients.

Medicare Administrative Contractor (MAC) – A private company that manages/administers certain aspects of the Medicare program such as processing Medicare Fee for Service (FFS) claims. There are 12 MAC **jurisdictions** and seven contractors (Noridian, NGS, Novitas, WPS, Palmetto, CGS and FCSO).

Prior Authorization Request (PAR) Contact – You can submit your prior authorization to your MAC and they will forward to the selected model participant for your area.

National Coverage Determination (NCD) – Medicare policy guidance to determine if an item or service is covered nationally. If there is an NCD in place, it is unlikely that you will see any LCDs in place for treatment.

Local Coverage Determination (LCD) – Medicare policy guidance to determine if an item or service is covered by the MAC coverage area.

Model participant – The vendors chosen by CMS to process prior authorizations on behalf of your MAC. These vendors are: Zyter, Genzeon Corporation, Innovaccer, Humata Health, Cohere Health and Vitrix Health.

Unique Tracking Number (UTN) – A 14-digit number provided to your office/hospital when the patient is approved; this number needs to be submitted on your Medicare claim submission.

Provider Transaction Access Number (PTAN) – A Medicare issued provider number primarily used for billing purposes.

Provisional affirmation - indicates that a future claim likely meets Medicare's coverage criteria, including coding and payment rules.

Additional support

If you have any questions regarding the Medicare WISeR Pilot or need help for your Medicare patients, you may contact Coloplast directly at us_marketaccess@coloplast.com or call (855) 230-7611. Our team of Reimbursement Specialists is available to help with these reimbursement matters for patients who have, or may soon receive, Coloplast products

References
1. https://www.cms.gov/files/document/wiser-fact-sheet.pdf.
2. WISeR Provider / Supplier Guide https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf.
3. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00310793

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