Alliance of Specialty Medicine

Sound Policy. Quality Care.

March 30, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Request for Information Related to Comprehensive Regulations to Uncover Suspicious Healthcare Activity (CRUSH) [CMS-6098-NC]**

Dear CMS Administrator:

The Alliance of Specialty Medicine (the "Alliance"), representing more than 100,000 specialty physicians from fifteen specialty and subspecialty societies, is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write to provide feedback on the aforementioned request for information (RFI) regarding potential regulatory actions to strengthen program integrity and uncover suspicious healthcare activity in federal healthcare programs.

## General Comments

The Alliance appreciates and supports efforts to identify and prevent fraud, waste, and abuse in Medicare and other federal health programs. We agree that protecting Medicare beneficiaries, safeguarding taxpayer dollars, and preserving the long-term sustainability of the Medicare program are critically important goals, particularly as policymakers face growing concerns about the program's solvency. At the same time, polices to address program integrity must be carefully designed to ensure that they do not inadvertently disrupt patient care or impose unnecessary administrative burdens on physicians furnishing medically necessary services to Medicare beneficiaries.

Specialty physicians frequently report that administrative requirements, including utilization management (e.g., prior authorization, step therapy), medical record and documentation requests, and those related to billing, coding and compliance, can delay access to medically necessary care and treatment. When administrative policies are overly rigid or poorly targeted, they risk penalizing physicians acting in good faith while doing little to deter fraudulent actors. As the agency considers new regulatory approaches to strengthen program integrity, ***we urge CMS to ensure that its policies maintain appropriate safeguards for beneficiary access and specialty physician participation in the Medicare program***.

With that context, the Alliance offers the following observations and recommendations regarding several areas discussed in the RFI.

## Modifications to Program Integrity Requirements

Several Alliance organizations have heard from their specialty physician members that CMS' newly implemented Wasteful and Inappropriate Service Reduction (WISeR) Model has increased administrative and operational burdens on physician practices and their staff on top of the already significant utilization management requirements prevalent in the private sector, including Medicare Advantage. Physicians are particularly concerned that the model introduces automated decision tools into an already complex utilization management environment. While the Alliance strongly supports efforts to combat fraud, waste, and abuse in the Medicare program, expanding prior authorization requirements within traditional Medicare – especially when supported by unproven artificial intelligence and other algorithmic technologies – risks delaying care for beneficiaries and raises significant concerns regarding transparency, clinical oversight, and patient access to timely specialty care.

For years, the Alliance, along with the broader clinician community, has raised concerns about the impact of utilization management tactics on access to care – namely prior authorization and step therapy. Physician surveys conducted by the American Medical Association (AMA) in 2024 illustrate the scope of this burden. Based on the responses of 1,000 specialty and primary care physicians, practices spend an average of 13 hours per week managing prior authorization requests, and 40 percent report having staff dedicated exclusively to this function. Nearly all physicians (93 percent) report that prior authorization delays patient care, while 82 percent say it can lead to treatment abandonment, and 29 percent report that delays have resulted in a serious adverse event for a patient in their care.[1]

Medicare Advantage plans' utilization management requirements have been especially challenging for specialty care, and federal agencies have identified similar concerns in their oversight of the program. In 2022, the Department of Health and Human Services Office of Inspector General (OIG) found that some prior authorization denials were issued for services that met Medicare coverage rules,[2] and in 2025, the Government Accountability Office (GAO) recommended that CMS strengthen oversight of the clinical criteria plans use when making prior authorization determinations.[3]

Indeed, CMS has taken steps to improve transparency and oversight of prior authorization practices. In 2024, CMS finalized the Advancing Interoperability and Prior Authorization final rule, which requires impacted payers, including Medicare Advantage plans, to comply with several new standards for prior authorization. These include making prior authorization decisions within 72 hours for expedited requests and within 7 calendar days for standard requests, providing specific reasons for any denial, and publicly reporting prior authorization metrics, including approval and denial rates, appeals outcomes, and average decision times for most items and services.[4,5] A proposal to apply similar requirements to medications under Medicare Parts B and D is under review by the Office of Management and Budget (OMB) and expected to be released shortly. [6]

More recently, CMS also secured commitments from major insurers to streamline prior authorization during a June 2025 roundtable,[7] and in December 2025 announced a voluntary pilot to collect service-level data on Medicare Advantage coverage determinations and appeals before expanding the reporting requirement to all plans in 2027,[8] building on those pledges.

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[1] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[2] https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf
[3] https://www.gao.gov/assets/gao-25-107342.pdf
[4] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[5] https://www.cms.gov/files/document/prior-authorization-metrics-reporting-overview-template.pdf
[6] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202504&RIN=0938-AV44
[7] https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html
[8] https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-december-15-19

Concerns regarding the impact of prior authorization and other utilization management practices on beneficiary access to care have also prompted congressional action. The Alliance has supported reforms such as the *Improving Seniors' Timely Access to Care Act* (H.R. 3514/S. 1816), which would streamline prior authorization processes and improve transparency in Medicare Advantage, as well as the *Safe Step Act* (H.R. 5509/S. 2903), which would require group health plans to provide a clear and timely exceptions process when step therapy is not in a patient's best interest, including when the required treatment has been ineffective or is expected to be ineffective and delaying care could risk irreversible harm. Lawmakers have also introduced additional legislation addressing utilization management practices, including the *Ban AI Denials in Medicare Act* (H.R. 6361), which would prohibit the use of AI-based prior authorization tools in Medicare demonstration programs, and the *Seniors Deserve SMARTER Care Act* (H.R. 5940/S. 3480), which sought to repeal the WISeR model.

Despite these oversight efforts in Medicare Advantage, CMS has implemented the WISeR Model in traditional Medicare. Prior to its implementation, numerous physician and provider organizations warned that the model could introduce administrative burden, delay patient care, and raise transparency concerns regarding the role of private vendors and automated decision tools used to evaluate medical necessity. CMS' WISeR Provider and Supplier Guide indicates that requests are submitted through contractor-operated platforms that use automated tools to evaluate and triage requests before clinical review occurs, with requests either affirmed or routed for additional review.[9]

Although the model has only recently been implemented, specialists are already reporting operational challenges, including significant confusion and lack of clarity in WISeR processes. Stakeholders report inconsistent guidance on facility requirements and documentation expectations, making it difficult to clearly communicate requirements to patients even when standard protections, such as Advance Beneficiary Notices (ABNs), are in place. Compared to other payers, WISeR has proven more difficult to navigate and administratively burdensome, with technology issues and limited support further disrupting workflow and, in some cases, contributing to delays or cancellations of care due to patient uncertainty.

In addition, we have heard reports that WISeR participants are requiring documentation beyond what is specified in local coverage determinations and are denying requests based on arbitrary utilization thresholds that do not consider whether services above the threshold are medically reasonable and necessary. These concerns underscore the need for greater transparency and consistency in Medicare coverage criteria, particularly national and local coverage determinations. When coverage requirements are unclear or interpreted differently across contractors, well-intentioned physicians may inadvertently fall out of compliance due to confusion, diverting time and resources away from patient care while doing little to identify or deter fraudulent actors.

The use of AI-driven algorithmic tools in prior authorization decisions adds another layer to already complex processes and raises important transparency concerns. These systems lack visibility into how requests are evaluated and triaged, including how algorithms determine whether a request proceeds directly to affirmation or is routed for clinical review. While CMS guidance indicates that non-affirmation determinations involve review by a clinician, automated systems may still influence how documentation is evaluated and how requests move through the review process. CMS guidance also indicates that these models may evolve as additional requests are processed, raising questions about how clinical standards are incorporated into their decision-making processes. Recent litigation involving UnitedHealthcare, in which plaintiffs allege that an algorithm used to manage claims overrode physicians' clinical judgment,[10] further underscores the importance

[9] https://www.cms.gov/priorities/innovation/files/wiser-provider-supplier-guide.pdf
[10] https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/11/Estate-of-Gene-B.-Lokken-et-al-v.-UnitedHealth-Group-Inc.-et-al_2026_3_9_ORDER-ON-MOTION-TO-COMPEL-DISCOVERY.pdf

of transparency and appropriate clinical oversight when automated technologies are incorporated into utilization management.

Finally, while prior authorization may play a role in certain program integrity efforts, many large Medicare fraud schemes involve high-volume billing patterns that become apparent only after claims data are analyzed over time. Recent enforcement actions involving durable medical equipment and telemedicine schemes demonstrate that fraudulent actors often submit documentation that appears valid but later proves to be fabricated or associated with services never provided. In these cases, fraud was identified through claims analytics and targeted investigative tools, not broad prior authorization requirements applied across the provider community.

***For these reasons, the Alliance urges CMS to pause further implementation and expansion of the WISeR Model while the agency evaluates its impact on beneficiary access to care and physician administrative burden, incorporates improvements identified by impacted specialties, and provides clear, standardized medical necessity criteria and consistent guidance to reduce confusion and avoid delays in care.***

## Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions

The Alliance appreciates how timely filing requirements may promote efficient claims processing and enable CMS to identify irregular billing patterns. However, rigid or inconsistently applied filing deadlines can create significant challenges for specialty physicians and their practices and may unintentionally hinder care delivery, especially by new physicians.

Specialty physicians frequently encounter circumstances outside their control that can delay claims submission. These circumstances may include coordination of benefits issues under Medicare Secondary Payer rules, provider enrollment and credentialing delays, and other administrative processing actions taken by Medicare contractors. In these situations, services may have been appropriately furnished and documented, but physicians may nonetheless face claim denials solely because filing deadlines were exceeded.

Strict application of timely filing policies in these circumstances does little to deter fraud or abuse. Instead, these policies can penalize physicians acting in good faith while navigating complex administrative processes required by the Medicare program itself. This issue can be particularly acute for newly credentialed physicians. In many cases, physicians begin furnishing services to Medicare beneficiaries while their enrollment applications are under review. Although CMS permits claims to be submitted once enrollment is finalized and a billing number is issued, lengthy credentialing and enrollment review timelines, particularly as CMS strengthens program integrity oversight, could create circumstances where services were appropriately furnished but cannot be billed because the timely filing window has shortened. In specialties experiencing physician shortages and in rural or underserved areas where timely access to specialty care is already limited, this would be particularly problematic. Physicians who are newly joining a practice or community should not face financial penalties for administrative delays associated with the cumbersome Medicare enrollment process.

***If CMS moves forward with shortened timely filing requirements (e.g., 90 days, 180 days), it should ensure appropriate safeguards are in place to prevent physicians from being penalized for delays outside of their control. This should include allowing claims associated with services furnished during the physician enrollment review period to be submitted once enrollment is approved, and exceptions for claims delayed due to contractor actions.***

## Preclusion List and Medicare Advantage Enrollment Requirements

In the Contract Year 2019 Medicare Advantage and Part D final rule, CMS replaced prior requirements that prescribers of Part D drugs and providers furnishing services to Medicare Advantage enrollees enroll in the Medicare Fee-for-Service (FFS) program as a condition of payment. Instead, CMS adopted a risk-based

approach centered on the Medicare "preclusion list," under which Part D plans must reject claims for drugs prescribed by clinicians on the list and Medicare Advantage plans may not cover services furnished by providers on the list. CMS explained that this targeted approach would reduce administrative burden while allowing the agency to focus program integrity efforts on providers who pose demonstrable risks to the Medicare program.

Now, CMS is seeking feedback on whether additional changes to the preclusion list, or new requirements for providers and suppliers to enroll in the Medicare FFS program as a condition of billing Medicare Advantage plans, may be necessary to address concerns that some providers revoked from the FFS program may continue billing through Medicare Advantage plans.

As CMS considers potential modifications, the Alliance encourages the agency to maintain the risk-based approach that underlies the current preclusion list policy, which allows CMS to focus oversight on providers who pose demonstrable risks to the Medicare program while minimizing unnecessary administrative burden on physicians and suppliers operating in accordance with program requirements. As the Alliance has previously noted in comments on the preclusion list policy, decisions that may result in placement on the preclusion list must be grounded in clear, objective, and transparent standards. Because inclusion on the list can have significant professional and financial consequences, including the inability to furnish services to Medicare Advantage beneficiaries or prescribe Part D drugs, these determinations should be applied carefully and consistently. For this reason, the criteria used to determine whether a provider's conduct is "*detrimental to the best interests of the Medicare program*" should be clearly defined and applied consistently. Subjective determinations based on broadly defined factors may create uncertainty for good-faith physicians and risk unintended consequences for beneficiary access to care.

***Accordingly, if CMS determines that changes to the preclusion list or enrollment requirements are warranted, the Alliance urges the agency to ensure that the criteria used to identify physicians who pose program integrity risks are clear, objective, and transparent. Physicians should also be afforded meaningful notice and an opportunity to respond before significant enforcement actions are taken. Finally, any changes to the standards governing the preclusion list should be established through transparent notice-and-comment rulemaking.***

These safeguards will help ensure that program integrity initiatives remain focused on demonstrably problematic actors while protecting compliant physicians who are delivering necessary care to Medicare beneficiaries.

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We appreciate the opportunity to provide feedback on the CRUSH RFI. Should you have any questions or would like to meet with the Alliance to discuss these recommendations further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology – Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography

American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
National Association of Spine Specialists
The Society of Interventional Radiology