

Aligning with CMS changes to inpatient only & ASC procedure/outpatient hospital lists

Arkansas Blue Cross and Blue Shield and its affiliated health plans (Arkansas Blue Medicare, BlueAdvantage Administrators of Arkansas, Health Advantage, Octave Blue Cross and Blue Shield and Skai Blue Cross and Blue Shield) are **aligning with changes** recently made by the **Centers for Medicare & Medicaid Services (CMS)** regarding **allowed sites of care** for more than 574 clinical procedures.

The changes will apply to dates of service of **August 1, 2026**, or thereafter.

As of January 1, 2026, CMS:

- **Removed 285 mostly musculoskeletal procedures** from its list of procedures that must be performed in an **inpatient hospital** to be covered (and thus paid for) by Medicare or Medicaid. This change **does not preclude** those procedures from being performed at in inpatient hospital – it merely means they may be performed in an **outpatient hospital** setting (based at a hospital but not requiring an overnight stay) when clinically appropriate. See the list of removed procedures in Table 119 of the CMS Final rule at <https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/975a33fe-e4b9-41ad-92b4-8f6bbfc25293/UploadedImages/documents/regulatory/medicare/2026/medicare-ops-asc-final-rule-2026.pdf>.
- **Added another 289 procedures** (from a wide range of clinical categories) to its list of covered procedures that may be performed in an **ambulatory surgery center (ASC)** or **outpatient hospital** setting, when clinically appropriate. ASCs are not located inside an inpatient hospital and cannot accommodate an overnight stay. See the list of added procedures in Tables 131 and 132 at <https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/975a33fe-e4b9-41ad-92b4-8f6bbfc25293/UploadedImages/documents/regulatory/medicare/2026/medicare-ops-asc-final-rule-2026.pdf>.

The CMS changes will be adopted for Arkansas Blue Cross and all of its affiliated health plans (**all lines of business**), both fully insured (those for which claims are paid from the insurance company's funds) and self-funded (those paying claims from their own funds).

The CMS changes are in line with the federal agency's belief that "the evolving nature of the practice of medicine allows more procedures to be performed on an outpatient basis with a shorter recovery time" and give healthcare providers **greater flexibility** in determining the **most appropriate site** of service.

For members of **self-funded** group health plans, a **pre-service review** is necessary to verify whether the desired site of care meets the clinical criteria for evidence-based medical necessity and level of care.

For members of **fully insured** group and individual health plans, healthcare providers can voluntarily submit an **organizational determination of benefits inquiry prior** to scheduling affected procedures to allow for a pre-service review of evidence-based medical necessity and the site's level of care. These procedures are subject to **post-service utilization management** reviews. If an organizational determination of benefits inquiry is not submitted prior to the procedure, it increases the chances of the claim being denied if the procedure is deemed not to meet the criteria for medical necessity and the level of care the site should be able to provide.