Upcoming Change to Elective Procedure Authorization with Inpatient Admission Review Requirements

Effective November 1, 2026

Notice of Material Amendment

As part of our ongoing efforts to streamline utilization management processes and ensure inpatient admissions are evaluated based on the member's clinical condition and medical necessity at the time services are rendered, **Arkansas Blue Cross and Blue Shield** is updating the review process for elective procedures that may result in inpatient admission.

What's Changing?

Effective November 1, 2026, Arkansas Blue Cross and Blue Shield will no longer review or authorize inpatient level of care as part of the prior authorization process for elective procedures. *

Providers should continue to obtain prior authorization for elective procedures when required by the member's benefit plan. Authorization decisions will apply only to the requested procedure and will not include a determination regarding inpatient level of care.

This approach is similar to a process implemented by other Blue plans where elective procedures continue to be authorized while inpatient status is evaluated separately based on the member's clinical condition and supporting documentation following the procedure. Separating procedure authorization from the inpatient level-of-care review will provide greater clarity when inpatient care is not approved because observation or outpatient care is determined to be the more appropriate setting. In these situations, the denial applies only to the inpatient admission and does not affect approval of the procedure or services that do not require prior authorization.

New Inpatient Admission Notification Process

If an inpatient stay is required following an elective procedure:

- The facility submits an Inpatient Admission Notification on the date of the procedure or admission by submitting a request through the portal or by faxing an Arkansas Authorization | Organizational Determination Request Form.
- Clinical documentation supporting the need for inpatient care must be available for review.
- The inpatient admission will be reviewed separately to determine medical necessity for the inpatient level of care.

- Authorization of the elective procedure does not guarantee approval of inpatient an admission.

Provider Action Required

Beginning November 1, 2026:

1. Continue to request prior authorization for elective procedures when required.
2. Do not request inpatient authorization as part of the elective procedure authorization submission.
3. Submit an inpatient admission notification on the day of the procedure if the member's condition warrants inpatient admission.
4. Maintain complete clinical documentation to support the medical necessity of the inpatient stay. If an inpatient admission review does not support inpatient level of care, the admission may be denied at the inpatient level and determined to be appropriate for coverage at an observation or outpatient level of care based on the clinical information submitted.

***Exceptions**

This change does not apply to:

- Federal Employee Program (FEP) members
- Medicare Advantage members

Current authorization and admission review requirements will remain in place for these lines of business unless otherwise communicated.

Frequently Asked Questions

Q: Is prior authorization still required for elective procedures?

A: Yes. Existing prior authorization requirements for elective procedures remain unchanged. Requirements vary depending on the member's plan.

Q: Will inpatient level of care continue to be reviewed during the procedure authorization process for elective procedures?

A: No. Effective November 1, 2026, inpatient level-of-care determinations will no longer be made during the elective procedure authorization review. See Exceptions.

Q: What should providers do if a member requires inpatient admission after an elective procedure?

A: Submit an inpatient admission notification on the date of service/admission and provide supporting clinical information when requested.

Q: Does approval of the elective procedure mean the inpatient stay is approved?

A: No. Inpatient admissions will be reviewed separately based on medical necessity and the member's clinical presentation.

Q: What happens if the inpatient admission does not meet medical necessity criteria for an inpatient level of care?

A: If the clinical documentation does not support inpatient level of care, the inpatient admission may be denied. In these situations, the member's services may still be considered medically necessary; however, observation would be the appropriate level of care rather than inpatient. Reimbursement will be determined based on the appropriate level of care.

Q: How should providers request a voluntary review (Organizational Determination/Benefit Inquiry - ODBI) for an elective procedure that may result in an inpatient admission?

A: The ODBI process will follow the same workflow as the prior authorization process. Providers should can submit the request for review of the outpatient service or procedure only. Inpatient level of care will not be reviewed as part of the ODBI request. If the member requires an inpatient admission following the procedure, the facility must [SJ5.1]should submit an inpatient admission notification on the date of the procedure or admission for separate review of the inpatient level of care.

Questions?

For questions regarding this change, please contact **Provider Services at** 501-210-7050 or your **Network Development Representative**.

Thank you for your continued partnership and commitment to providing high-quality care to our members.

Arkansas Blue Cross and Blue Shield

Utilization Management Team