PAYER POLICY PLAYBOOK

Appeals & Policy Changes

Q1 2026 Issue

AI-Driven Payer Landscape:
Making the Human Case

Automated utilization review isn't slowing down—and in 2026, its fingerprints are on more denials than ever.

Health plans are leaning heavily on AI-powered tools to apply MCG and InterQual criteria at scale. The result? Decisions that are faster, more standardized, and increasingly disconnected from the patient in front of you.

These systems weren't built to weigh comorbidities, catch subtle signs of deterioration, or account for the clinical judgment that led a provider to escalate care in the first place.

That gap is your opportunity.

MCG and InterQual remain your foundation—know them, use them, anchor your appeals in them. But your strongest cases go further.

They tell the story the algorithm can't read: the patient whose outpatient course already failed, the one whose instability made a lower level of care genuinely unsafe, the one whose readmission risk was too real to ignore.

Payer AI looks for criteria. A well-built appeal explains why this patient, at this moment, needed inpatient care—and makes that case impossible to dismiss with a checkbox. As automated review expands, clinical storytelling isn't a soft skill. It's your most effective appeals tool.

The Details That Win

MCG and InterQual aren't going anywhere—they're still the backbone of every solid appeal. But as payer AI takes on more of the review process, the criteria alone don't always tell the full story.

Automated systems are built for pattern-matching, not nuance. What they often miss is exactly what matters most: a patient's compounding complexity, early signs of deterioration, or the very real risk that anything short of inpatient care would have failed them.

When you build appeals, go beyond the criteria:

1. **Emphasize patient-specific risk**
2. **Highlight failure of outpatient care**
3. **Document comorbidities and deterioration risk**

Bottom line:

Don't just cite the criteria. Connect the dots. The nuances automated systems miss are exactly where your appeals should live.

2026 Trend: AI-Driven Denials

- **Algorithm-generated denial language**
- **Guideline mismatch citations**
- **Minimal patient-specific reasoning**

Key Updates

Medicare Inpatient-Only (IPO) 2026 Changes

KEY CHANGES

Effective January 1, 2026

285 Procedures Removed
Hundreds of musculoskeletal codes eligible for outpatient setting

Elimination by 2028
Full elimination of the IPO list within 3 years

Site-of-Service Shift
Governed by site-of-service coverage regulations

No Guarantee of Coverage
Services are still subject to Medicare rules

What's Changing in 2026

The IPO list is going away—and the impact is already here.

CMS is eliminating 285 musculoskeletal and related surgical procedures—including complex orthopedic and spine codes—in 2026, with the full phase-out ending in January 2028.

With IPO protections removed for these procedures, inpatient status can no longer be assumed. Admissions must now be justified on clinical merits:

- Two-midnight-stay benchmark
- Clinical risk and complexity
- Post-operative care needs
- Clear documentation supporting risk and recovery trajectory

2026 IPO Denials: Your Appeals Roadmap

As CMS continues phasing out the IPO list, one thing is clear: the absence of a procedure from that list is not—on its own—a winning appeals argument.

Your team should shift the foundation. Inpatient determinations must be grounded in CMS medical necessity standards, backed by MCG or InterQual, and built around the clinical picture of the specific patient.

The IPO list's evolution doesn't change what makes an admission medically necessary—it just changes where teams sometimes mistakenly anchor their case.

> CMS guidance emphasizes that removal from the IPO list does not equate to appropriateness for inpatient management and does not supersede clinical judgment. Per CMS criteria beyond the IPO list, this patient met inpatient medical necessity based on severity of illness, expected need for hospital-level services exceeding two midnights, and clinical risk factors requiring inpatient monitoring and management. [MCG or InterQual] criteria further support this determination.

Appeals Nurse Briefing:
Aetna’s 2026 Level of Severity Policy

Aetna's Level of Severity Inpatient Payment Policy, effective January 1, 2026, introduces a major shift in how inpatient stays are reimbursed for Aetna Medicare Advantage and Special Needs Plan (SNP) members. Understanding the new structure is essential for your team preparing to defend inpatient level of care (IP LOC) determinations.

What Changed?

A Two-Tier Severity System Based on Length of Stay

1. Aetna now categorizes inpatient reimbursement largely by midnight count.
2. Stays ≥5 midnights will not undergo severity review and will be paid at the full inpatient DRG rate.
3. Stays of 1–4 midnights will undergo a level-of-severity review using MCG criteria to determine whether Aetna pays at a higher-severity inpatient rate or downgrades payment to a lower-severity rate similar to observation.
4. Aetna's new model no longer denies IP admissions outright for failing medical necessity criteria; instead, it adjusts payment downward for cases of 1–4 midnights judged "low severity." Aetna will still approve the inpatient admission—but payment may be lower.

Stays of 5+ Midnights: Automatic Full IP Rate

Any stay of ≥5 midnights is automatically eligible for full DRG-level inpatient reimbursement with no severity review. These cases should never be downgraded—and any such denial warrants an immediate challenge citing Aetna's own policy. To view the full policy, click here: Aetna Level of Severity Inpatient Payment Policy

Bottom Line for Your Team

Aetna cases > 5 midnights = automatic full inpatient payment case

If downgraded/denied IP LOC: appeal immediately citing payer’s policy

For 1-4 midnights: tailor appeal to MCG inpatient criteria, severity, and risk-flag mis-categorizations

Remember:

These might appear to be paid as inpatient claims, but at a lower level of care.

We should argue the inpatient level of care at the level billed on the claim.

Q1 2026 Payer Updates:
What Your Team Needs to Know

Anthem [Elevance Health] Medicare Advantage

Effective January 1, 2026, Anthem Medicare Advantage (MA) will no longer allow denials to be overturned after a peer-to-peer review. Once an inpatient admission or length-of-stay denial is issued, providers must move directly to the formal appeal process.

Restrictions on Reopening Approved Admissions | CMS rules for 2026 further restrict all MA plans, including Anthem, from reopening or changing a previously approved inpatient admission unless there is clear evidence of fraud or obvious error.

Stricter Documentation Standards | Anthem is also increasing documentation requirements for complex cases or cases with prior coverage transitions, which may increase the likelihood of denials when medical records are incomplete.

Readmission and Inpatient Status Denials | As CMS strengthens protections around inpatient approvals in the 2026 final rule, Anthem is expected to increase scrutiny of compliance with the two-midnight benchmark. When the stay legitimately meets the two-midnight expectation, CMS's new guardrails make it more difficult for MA plans to downgrade approved inpatient admissions retrospectively.

Key Takeaways

- Effective January 1, 2026, Anthem MA denials can't be overturned after a peer-to-peer review; must go straight to formal appeal.
- CMS will further restrict MA plans from reopening or changing inpatient admissions unless there is evidence of fraud or obvious error.
- Anthem is increasing documentation requirements, with greater scrutiny on complex cases and prior coverage transitions.

Be on the lookout

This may support arguments for retractions from Medicare Advantage plans.

Blue Cross Blue Shield

Blue Cross Blue Shield's 2026 changes expand coverage restrictions and biosimilar preferences—shifts that will directly affect denial volume and the level of clinical documentation required to support appeals.

More "Non-Covered Drug" Denials | BCBS plans are removing coverage for ADHD meds (Adderall XR, Concerta, Vyvanse), migraine meds (Almotriptan), GI drugs (Alosetron 1 mg), topical anti-inflammatories, and multiple inflammatory biologics beginning Jan 1, 2026.

Biosimilar-First Requirements Increasing | North Carolina Blue Cross will prefer Epysqli for eculizumab products, and Denosumab biosimilars Jubbonti, Stoboclo, Wyost, and Osenvelt over Prolia/Xgeva starting Jan 1, 2026, resulting in more preferred-agent and step-therapy denials.

Key Takeaways

Expect more outpatient medication denials requiring alternative-failure documentation and clinical justification for nonpreferred therapies. Appeals will need a clear rationale for why a patient cannot safely transition to the preferred biosimilar, as well as evidence of clinical appropriateness.

Centers for Medicare & Medicaid Services

New federal regulations in 2026 cut both ways. Some create real protections for providers. Others open the door to increased scrutiny. Your team needs to know the difference.

MA Plans Can No Longer Overturn Approved Inpatient Admissions | Starting in 2026, CMS prohibits Medicare Advantage plans from retroactively downgrading an approved inpatient admission unless there is clear evidence of fraud or obvious administrative error.

Medicare Drug Price Negotiation Will Tighten Formularies | CMS implementation of Medicare drug price negotiation is prompting payers to prepare for tighter formulary controls, which may lead to more step-therapy denials and stricter enforcement of preferred-drug requirements.

Key Takeaways

Cite this whenever a payer tries to issue a retroactive denial of an already-approved inpatient stay. Expect more formulary-based denials and be ready to document clinical need when a patient cannot use the preferred or negotiated agent.

Humana

Humana's 2026 updates may appear to reduce administrative work, but they are likely to increase downstream denials.

Prior Auths Are Down—Denials Are Not | While the payer is removing about one-third of outpatient prior authorizations—including CT/MRI, colonoscopies, and transthoracic echocardiograms—Humana is simultaneously tightening coding-driven claim edits, which may result in more retrospective denials for documentation gaps or coding specificity issues.

Technical Edits Are Expanding | Humana is expanding technical edits for biosimilars, NICU services, and biomarker testing, all areas with high complexity and strict billing rules. These edits frequently trigger denials tied to missing modifiers, incomplete test justification, or mismatched clinical documentation.

Key Takeaways

The reduction in prior authorizations doesn't mean less work—it means the risk shifts to the back end. Focus internal audits on coding accuracy and documentation completeness, especially for biosimilars, NICU services, and biomarker testing.

United Healthcare (UHC)

UHC's 2026 updates will significantly influence denial trends, particularly in medication and coding reviews.

Specialty Drug Prior Authorizations Are Expanding | UHC is adding prior authorization requirements for high-cost injectables, gene therapies, immune globulins, and similar advanced treatments—changes expected to increase medication-related denials.

New Coding Rules Take Effect in Phases | Beginning early 2026, UHC will also enforce several new coding rules, including anatomical modifier requirements (Feb 1), ICD-10 excludes conflict edits (Mar 1), and stricter radiology documentation standards (Apr 1). These changes will drive more technical denials, even when clinical necessity is supported.

Key Takeaways

UHC's 2026 updates signal a shift toward post-claim technical auditing. Prioritize modifier accuracy, thorough radiology documentation, and pre-submission review of high-cost drug claims. Documentation completeness will be the deciding factor in avoiding and overturning denials.

Resources & Links

Aetna – 2026

1. **Aetna OfficeLink Update |**
   https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-november-2025-olu-edition-11-6.pdf

2. **Understanding Aetna's Level of Severity Policy, AppriseMD |**
   https://apprisemd.com/understanding-aetnas-new-level-of-severity-inpatient-payment-policy/

Anthem (Elevance Health) – 2026

1. **Anthem Medical Policies & Clinical UM Guidelines** |
   https://www.anthem.com/provider/policies/clinical-guidelines/

2. **Anthem Medical Policies & Clinical UM Updates Effective January 1,2026** |
   https://providernews.anthem.com/new-york/articles/medical-policies-and-clinical-utilization-management-guideli-27477

Blue Cross Blue Shield – 2026

1. **Blue Cross NC – Medicare Advantage Policy Changes Effective January 1, 2026** |
   https://www.bluecrossnc.com/providers/provider-news/2025/medicare-advantage-policy-changes-effective-01-01-2026

2. **Blue Cross NC – Change to Inpatient Status Determination for Elective Procedures** |
   https://www.bluecrossnc.com/providers/provider-news/2025/additional-guidance-on-change-inpatient-status-determination-elective-procedures-effective-02-01-2026

3. **BCBSIL Prior Authorization Changes Effective January 1, 2026** |
   https://www.bcbsil.com/provider/education/education-reference/news/2025/10-31-2025-prior-authorization-changes-for-some-commercial-and-government-program-members

Centers for Medicare & Medicaid Services (CMS) – 2026

1. **CY 2026 OPPS & ASC Final Rule (CMS-1834-FC)** |
2. https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center

3. **CMS CY 2026 OPPS/ASC Final Rule – Summary (Holland & Knight)** |
   https://www.hklaw.com/en/insights/publications/2025/11/cms-releases-cy-2026-hospital-opps-and-ambulatory-surgical-center

4. **CMS 2026 OPPS Final Rule – CDI/Appeals Summary (ACDIS)** |
   https://acdis.org/articles/news-cms-releases-2026-opps-final-rule-begins-inpatient-only-list-phase-out

Resources & Links (cont'd)

Humana – 2026

1. **Humana Medical & Pharmacy Coverage Policies** |
   https://mcp.humana.com/tad/tad_new/Home.aspx

2. **Humana 2026 Provider Manual |**
   https://assets.humana.com/is/content/humana/FINAL_773902ALL0725-B_2026_ProviderManual-NonDelegated_formattedpdf

UnitedHealthcare – 2026

1. **Hospital Services: Observation and Inpatient (Commercial & Exchange)** |
   https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/hospital-services-observation-inpatient.pdf

2. **Elective Inpatient Services Policy (Commercial & Exchange)** |
   https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/elective-inpatient-services.pdf

3. **Hospital, Emergency & Ambulance Services (Medicare Advantage)** |
   https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-mp/hospital-services.pdf

4. **UnitedHealthcare Policies & Protocols Library** |
   https://www.uhcprovider.com/en/policies-protocols.html