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THE LIVANTA CLAIMS REVIEW ADVISOR

A monthly publication to raise awareness, share findings, and provide guidance about Livanta's Claim Review Services

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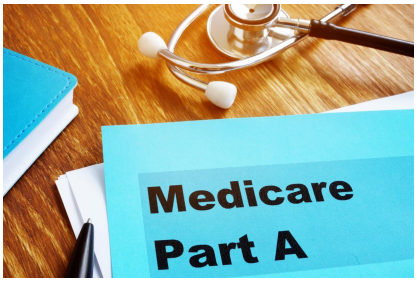
Short Stay Review – Acute Abdominal Conditions

The Two-Midnight Rule



This month's edition of the *Livanta Claims Review Advisor* focuses on the diagnosis and payment of acute abdominal conditions, considering the CMS Two-Midnight Claim Review Guideline.

The Centers for Medicare & Medicaid Services (CMS) implemented the Two-Midnight Rule in Fiscal Year 2014 (FY2014) to help determine when inpatient admission is appropriate for payment under Medicare Part A. Medicare Part A covers inpatient hospital services. Under the Two-Midnight Rule, inpatient admission is generally appropriate for Medicare Part A payment if the physician or other qualified practitioner admits the patient as an inpatient based upon the expectation that the patient will need hospital care that crosses at least two midnights. The medical record must also support that expectation.

The Two-Midnight Rule includes two distinct, related medical review standards: (1) a two-midnight presumption and (2) a two-midnight benchmark. The two-midnight presumption applies to hospital claims with lengths of stay that span two or more midnights from the time of inpatient admission to the time of discharge. In general, these claims are appropriate for Medicare Part A payment and, thus, are not the focus of medical review efforts. In contrast, the two-midnight benchmark applies to claims with inpatient lengths of stay less than two midnights. For these claims, the Rule defines conditions that meet Part A payment requirements.

In the FY2016 Outpatient Prospective Payment System (OPPS) Final Rule, CMS

amended the Two-Midnight Rule to clarify that Medicare would allow exceptions to the two-midnight benchmark. These exceptions are determined on a case-by-case basis by the physician responsible for the care of the patient and are subject to medical review.

The Two-Midnight Rule does not apply to procedures on the Inpatient-Only List.

Acute Abdominal Conditions

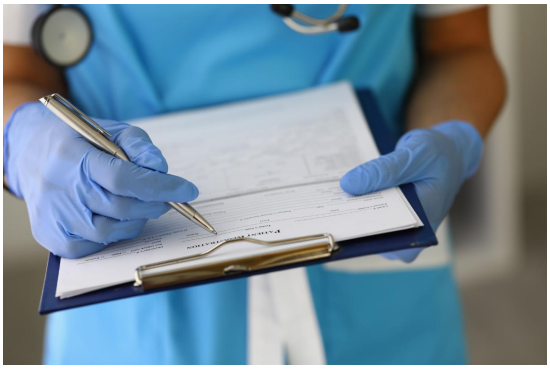
Abdominal pain is the most common reason for emergency department (ED) visits in adults. It accounted for 7% of all ED visits in 2006 (1). Abdominal pain can be caused by a variety of disease processes, such as infectious or non-infectious gastroenteritis, biliary tract disease, appendicitis, diverticulitis, trauma, and pathologies of the urogenital, thoracic, and vascular systems. When accompanied by vomiting and diarrhea, in addition to identifying the causative pathology there is also a concern for identifying and treating any associated dehydration or metabolic abnormalities. Severe vomiting and diarrhea can cause metabolic changes, including alkalosis or acidosis.

Initial evaluation is focused on identifying conditions that may require acute intervention. These conditions include acute inflammatory conditions of the gastrointestinal (GI) and biliary tract, obstruction of the GI, biliary, or genitourinary (GU) tract, ischemia of intra-abdominal organs, and hemorrhage from a ruptured intra-abdominal or retroperitoneal vessel. The signs of an “acute abdomen” are well known and include distention, direct or rebound tenderness, guarding, rigidity, and high-pitched or absent bowel sounds. Evidence of a mass, including pulsatile masses, should be noted, along with the presence of abdominal bruits and the quality of femoral pulses. Imaging of the abdomen and retroperitoneum is common to confirm findings on examination.

Once an acute surgical emergency is excluded, attention can be directed toward a broader array of disease processes. The evaluation then focuses on the specific etiology of the condition and whether treatment requires hospitalization. A history of the duration, type, and location of the pain, along with aggravating or alleviating factors should be elicited and documented. Identifying evidence of an infectious process that may require antibiotics or metabolic derangements caused by nausea and vomiting is important.

Many patients with abdominal pain do not have a clear indication of a “surgical abdomen” but cannot be safely discharged from the ED. These patients require additional monitoring in a hospital setting to see how they respond to medical care such as nasogastric decompression, repletion of fluid and electrolytes, or antibiotic treatment. In most cases, initial response to treatment is reassessed within 24 hours.

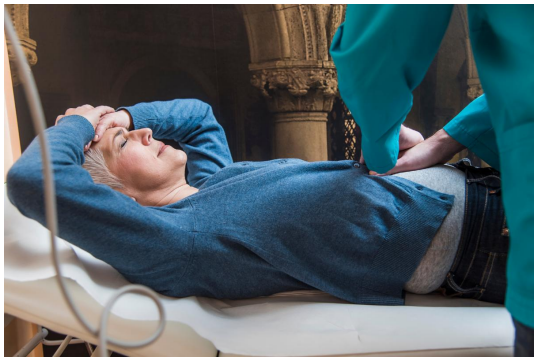
Inpatient Admission Considerations



When considering Medicare patients with abdominal pain for inpatient admission, Livanta advises that Steps 4 and 6 of the Two-Midnight Guideline be carefully considered. Many, but not all, patients with acute surgical problems can be reasonably expected to have a two-midnight stay. However, a significant number of patients with acute surgical conditions are routinely treated with same-day discharge or an overnight stay for extended recovery. This includes patients treated surgically for urolithiasis and uncomplicated appendicitis or cholecystitis. The provider should consider whether Step 6 (need for inpatient care despite the lack of a two-midnight expectation) would apply for those patients. If so, documentation should detail why inpatient care is required. If there is concern for risk of an adverse event in the postoperative period, this concern should be documented in the record.

Most patients without acute surgical conditions require monitoring of their condition, treatment with antibiotics, or fluid and electrolyte resuscitation. This care can often be provided in an outpatient setting, and many of these patients will improve enough for discharge within 24-36 hours of initiation of treatment. To support Part A payment upon review, the medical record should include clear documentation supporting the reasonable expectation that two midnights of hospital care will be needed. In some cases, it is unclear whether an acute surgical condition exists or may evolve at the time of inpatient admission. Documentation of concern about a serious adverse event and the need for inpatient care in these cases may qualify for Part A payment based on Step 6.

Common Abdominal Conditions



Non-infectious gastroenteritis is common in the community and is most often viral in origin. The treatment for non-infectious gastroenteritis is supportive. When patients are hospitalized, it is important to document the reasoning for admission and the plan of care. The ability to tolerate an oral diet and hydration is generally all that is required for discharge. Inpatient admission is typically not considered necessary, and supporting documentation in the medical record of the need for a two-midnight stay or inpatient care is necessary to satisfy Step 4 or 6 of the Two-Midnight Guideline. Livanta commonly encounters an assumption that a medical history of diabetes alone is sufficient to support the need for inpatient admission. This is a false assumption, as these patients can do quite well with proper blood sugar monitoring and management.

Upper gastrointestinal causes of abdominal pain include gastritis, diabetic gastropathy, ulcer disease, biliary colic, pancreatitis, nausea and vomiting associated with marijuana or opioid use, Crohn's disease, upper GI cancers, and adhesive disease of the small bowel. An acute surgical condition may exist when these conditions are accompanied by bleeding, obstruction, or perforation. When unaccompanied by those complications, admission is most often for monitoring, symptom control, antibiotic treatment, and fluid/electrolyte repletion. Observation is commonly 24-36 hours in uncomplicated cases. Symptoms in many of these patients may be controlled enough for discharge within 24-36 hours of the initiation of treatment. Often, the length of stay cannot be accurately assessed at the time of admission, and assessment of initial response to therapy is required. When inpatient status is chosen in these cases, Livanta advises that the reason for an expectation of two midnights for symptom control or resuscitation be clearly documented in the record. In the case of **pancreatitis**, the severity of the disease, including any systemic manifestation or organ dysfunction (Ranson Class) should be noted. If the reason for inpatient admission is suspicion for development of an acute event, then this suspicion should be documented in the record, along with a plan of care that supports the decision for inpatient admission. Patients admitted to inpatient status for GI bleeding should have documentation that supports concern for active bleeding and the need for possible acute intervention.

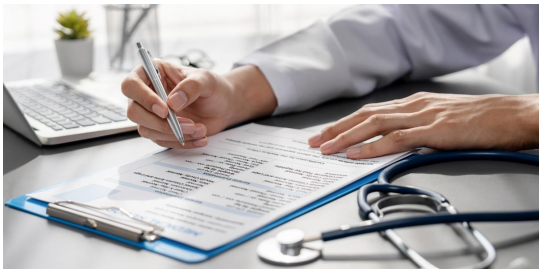
Lower abdominal conditions include constipation, colitides (especially Clostridioides difficile – C. diff), appendicitis, diverticulitis, lower GI bleeding, and benign and malignant colonic obstruction. As noted above, obstruction, perforation, or bleeding may result in the need for acute surgical intervention. The degree of concern for acute surgical intervention, especially in the case of bleeding, should be documented. When **diverticulitis** is present, the extent of the disease, including the presence of perforation or localized inflammation (Hinchey Class), along with any systemic manifestations, should be noted. **Appendicitis** may also have a range of presentations. Treatment guidelines for appendicitis and diverticulitis are evolving and depend on both the clinical presentation and imaging findings (2, 3). The rationale for a two-midnight expectation or the need for inpatient care despite the lack of a two-midnight expectation should be documented in the record. **Colitides** may be ischemic or infectious. C-difficile was traditionally considered a primary healthcare-associated infection, however, it is increasingly diagnosed within the community setting (4). C. diff infections can range from mild infections that can be treated as an outpatient with oral antibiotics to severe infections requiring emergent surgery for the removal of a diseased colon. The documentation in the medical record should reflect the clinician's suspicion for a surgical complication, such as toxic megacolon, or the need for extended hospitalization for hydration.

Other common causes of infectious colitis are Salmonella or Giardia. Most of these infections can be treated with oral antibiotics, with symptom improvement in 24-36 hours. Some cases pose a higher risk of complications, such as Enterohemorrhagic Escherichia coli, which results in bloody dysentery and an increased risk of hemolytic uremic syndrome (5). The documentation should be specific to the concern, as these infections can be mild to severe. They are caused by the bacteria producing Shiga and Shiga-like toxins; therefore, antibiotics are not indicated and can worsen the disease**. Ischemic colitis** is usually accompanied by severe pain and bloody diarrhea and is often seen in the presence of decreased perfusion. Diagnosis is by endoscopy and the patient may meet the requirements of the Two-Midnight Guideline at Step 6. There is a broad spectrum of

patients who present with **lower GI bleeding.** Documentation should focus on whether bleeding is ongoing, its impact on hemodynamics, and the potential need for an acute intervention.

Urologic problems may present as acute abdominal pain. The diagnosis is usually made by a combination of physical examination and imaging. Most of these problems result from **obstructive uropathy**. In the absence of signs of systemic sepsis or acute renal failure, the majority of these can be treated in an outpatient setting without intervention (e.g., lithotripsy, stent placement).

Documentation Recommendations



The evaluation and management of patients who present with acute abdominal conditions are diverse and challenging. Initial focus is on excluding conditions that require acute intervention, followed by an assessment of the impact of bleeding or fluid loss and the need for repletion. At the time of admission, it is important to consider the time reasonably expected to establish a diagnosis, adequately resuscitate the patient and relieve their symptoms sufficiently to allow discharge to outpatient care. When inpatient status is chosen, documentation should support the conclusion that two midnights of care are required to achieve those aims or that inpatient care is required for this patient based on Step 6 of the Two-Midnight Guideline.

Resources

1. Christopher R Macaluso, Robert M McNamara. Evaluation and management of acute abdominal pain in the emergency department. PMCID: PMC3468117 PMID: 23055768 **https://pmc.ncbi.nlm.nih.gov/articles/PMC3468117/**
2. Kumar SS, Collings AT, Lamm R, Haskins IN, Scholz S, Nepal P, Train AT, Athanasiadis DI, Pucher PH, Bradley JF 3rd, Hanna NM, Quinteros F, Narula N, Slater BJ. SAGES guideline for the diagnosis and treatment of appendicitis. Surg Endosc. 2024 Jun;38(6):2974-2994.
3. Hartofilis L, Riggins JK. Abdominal pain: update on emergency department management of appendicitis and diverticulitis. Emerg Med Pract. 2024 Oct 1;26(10):1-28.
4. Pradeep Kumar Mada: mohammed U. Alam. Clostridioides difficile infection. **https://www.ncbi.nlm.nih.gov/books/NBK431054/**
5. Rawish Fatima, Muhammad Aziz. Enterohemorrhagic Escherichia coli. **https://www.ncbi.nlm.nih.gov/books/NBK519509/**

About Livanta

Livanta is the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) conducting post-pay fee-for-service claim reviews of acute care inpatient hospitals, long-term acute care hospitals, and inpatient psychiatric facilities to

determine the appropriateness of Part A payment for short stay inpatient hospital claims. These claims are reviewed in accordance with the Two-Midnight Rule published in FY 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule CMS-1599-F, as revised by CMS-1633-F.

CMS issued the following BFCC-QIO Two-Midnight Claim Review Guideline that graphically depicts the tenets of the Two-Midnight Rule. Livanta utilizes this Guideline when making payment determinations for SSR claims.

CMS Two-Midnight Claim Review Guideline
https://www.cms.gov/sites/default/files/2022-04/BFCC-QIO-2-MidnightClaimReviewGuideline.%20508.pdf

Questions?

Should you have questions, please email **ClaimReview@Livanta.com**, or visit the claim review website for more information:
https://www.livantaqio.cms.gov/en/ClaimReview/index.html