Bundled Episode Payment and Gainsharing Demonstration*
Total Hip Replacement Definition

Component	Clinical/Payment
Summary Description	Episode includes all covered services provided to a "qualified" patient during the 90-day episode period for: • An index procedure of total or partial hip replacement for patients with degenerative osteoarthritis • Revision procedure performed during the episode period because of complications associated with the original procedure or for mechanical failure • Patient complications arising during the stay for index procedure • Treatment of any complications that arise related to the index or revision procedure (regardless of treatment setting) • Readmission of the patient during the 90-day episode period for one of the MS-DRGs defined in Attachment A, section IV.
Episode Period	0 to 90 days; Episode begins on date of admission for primary procedure and ends 90 days after the surgery date.
Dx, DRG and Procedure Codes	• See Attachment A
Standard Services	**Services expected within the episode period (may not be separately billed), include:** • IP Charges—everything that would be included by Medicare in DRG for facility (including prosthesis, testing, IP Rx) • IP Professional: Anesthesiologists, Radiologists, Hospitalists, Other consultants (e.g., cardiologist) • Surgeon/Asst Surgeon charges • X-rays and imaging • Services in optional outpatient rehab package, below, if negotiated **Services which, if they occur within the episode period, may not be separately billed:** • All services associated with readmissions as defined in Attachment A, section IV. • Facility charges for treatment of complications during episode period • Radiology charges for treatment of complications during episode period • Professional fees for treatment of complications during episode period (e.g., emergency medicine, internist, surgeon, anesthesiologist, cardiologist) • Facility charges, professional fees and ancillary charges while patient is located in an inpatient rehabilitation setting **Services excluded from Standard Definition, may be separately billed:** • Skilled nursing facilities • Physical Therapy (in home, or at hospital outpatient facility, except as included in Optional OP Rehab package) • Home Health Care /Nursing charges, except as included in Optional OP Rehab package • DME • OP Rx

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Outpatient Rehab	**Optional outpatient rehabilitation package.** Hospitals and health plans may optionally negotiate to include these services (make them not separately billable) during the 21 days following the date of surgery for the index procedure. • Initial evaluation by Physical Therapist • Evaluation by Home Health Aide or Occupational Therapist of physical environment of patient and need for equipment, e.g. braces, grabbers etc. Note: this usually starts with one visit in hospital, but home evaluation is also common. • Blood draws for INR for patients receiving anti-coagulants (e.g., warfarin) at frequency of 2X/week for 3 weeks. Done by Home Health Agency. (Note: About 50% of patients require).
Patient Qualification	**For inclusion in the pilot, patient must be:** • Covered (as primary plan) by a participating employer and health plan on date of surgery • Undergoing surgery provided by an orthopedic surgeon contracting to provide services under the pilot for the specific health plan • Being admitted to a hospital contracting to provide services under the pilot for the specific health plan • Over age 18 and under age 65 • Presenting for index procedure with an ASA rating of <3 (APR-DRG SOI level of 1 or 2) **Patients are excluded from the pilot when:** • Transferred at any time during initial hospital stay • Primary coverage with participating employer and health plan ends at any time during the episode • Clinical history demonstrates clinical condition of: o Active Cancer o HIV/AIDS o ESRD • BMI is 40 or greater
Outliers	No clinical definition (that is, all patients are inliers). Definition does not preclude negotiation of separate stop-loss contractual arrangements.

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Attachment A:
Codes: Total Hip Replacement

I. Index Procedure		
Index Procedure Code: This procedure must exist to trigger the episode. CPT: ▪ 27130—Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft, or ▪ 27125—Hemiarthroplasty, hip, partial (e.g. femoral stem prosthesis, bipolar arthroplasty) (when performed for reasons other than fracture) ICD-9 Px: ▪ 81.51—Total hip replacement ▪ 81.52—Partial hip replacement (when performed for reasons other than fracture) ▪ 00.85—Resurfacing hip, total, acetabulum and femoral head ▪ 00.86—Resurfacing hip, partial, femoral head	**DRG:** Episode must map to one of these DRGs. MS DRG 470 Major Joint Replacement or Reattachment of Lower Extremity without MCC AND APR DRG SOI of 1 or 2	**Diagnosis Exclusions:** Diagnosis (any position) must **NOT** equal one of the following: 714.0x—Rheumatoid Arthritis 736.89—Other acquired deformities, lower limb 170.7—Malignant neoplasm of long bones of lower limb 171.3—Malignant neoplasm of soft tissue, lower limb, hip 198.5—Secondary malignant neoplasm of bone, marrow 822, 823, 827, 828. 836, 891—Fractures, dislocations and open wounds 928—Crushing injury
II. Revision Procedure—Include only if performed within 90 days of primary procedure		
Procedure Code These procedure codes constitute a covered revision if performed within 90-days of index procedure CPT: • 27134—Revision of total hip arthroplasty; both components, with or without autgraft or allograft • 27137—Revision total hip arthroplasty, acetabular component only, with or without autgraft of allograft • 27138—Revision total hip arthroplasty, femoral component only, with or without autgraft or allograft ICD-9 Px: ▪ 00.70—Revision of hip repl, both acetabular and femoral components) ▪ 00.71—Revision of hip repl, acetabular component ▪ 00.72—Revision of hip repl, femoral component 00.73—Revision of hip replacement, acetabular liner and/or femoral head only ▪ 00.87—Resurfacing hip, partial, acetabulum	**DRG:** Admission must map to one of these DRGs. MS DRGs 466—Revision of hip or knee replacement with MCC 467—Revision of hip or knee replacement with CC 468—Revision of hip or knee replacement without CC/MCC **APR SOI limitation does not apply if patient was included in the pilot for the index procedure.**	**Included Diagnoses:** ▪ All

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III. Treatment of complications of index or revision procedure, during episode period regardless of treatment setting

Services provided to treat complications that begin during the episode period may not be separately billed during the episode period. Examples of complications include patients with wound issues, cellulitis, Service examples include: joint injection, pain management, X-Ray or MRI, dislocation, incision and drainage of hip joint, removal of hip prosthesis.

IV. Readmissions that begin within 90 days of index procedure

Readmissions that occur at an acute facility other than the one in which the index procedure was performed are excluded from the definition (may be separately billed).

Readmissions at the same facility that begin during the episode period may not be separately billed if the readmission maps to one of the DRGs listed below.

- 175, 176—Pumonary embolism
- 294, 295—Deep vein thrombophlebitis
- 463, 464, 465—Wnd debrid & skn grft, exc hand, for musculo-conn tiss dis
- 466, 467, 468—Revision of hip or knee replacement
- 480, 481, 482—Hip & Femur procedures except major joint
- 533, 534—Fractures of Femur
- 535, 536—Fractures hip and pelvis
- 537,538—Sprains, strains, dislocation hip , pelvis, thigh
- 539, 540, 541—Osteomyelitis
- 553, 554—Bone diseases & arthropathies
- 555, 556—Signs & symptoms of musculoskeletal system & conn tissue
- 559, 560, 561—Aftercare, musculoskeletal system & connective tissue
- 564, 565, 566—Other musculoskeletal sys & connective tissues diagnoses
- 602, 603—Cellulitis
- 856, 857, 858, 862, 863—Post-operative or post-traumatic infections
- 870, 871, 872—Septicemia or severe sepsis
- 901, 902, 903—Wound debridements for injuries
- 919, 920, 921—Complications of treatment
- 939, 940, 941—O.R. procedure with diagnosis of other contact w health services

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