**Knee Replacement Bundle**

**Component:** Criteria for Inclusion/Exclusion – Knee Replacement

**Overview:** Episodic payment for KR includes all services provided to a qualified patient during the episode period for: knee replacement for patient with degenerative osteoarthritis (Index Procedure)

* Revision procedure performed during the episode period because of complications associated with the original procedure or for mechanical failure
* Patient complications that arise during the inpatient stay for the index procedure
* Treatment of any complications related to the index or revision procedure, regardless of treatment setting
* Readmission of the patient during the episode period for conditions and complications arising from the procedure.

**Patient Qualifiers**

• Patient covered by a Quality Path employer on the date of surgery

• Surgery provided by a QualityPath physician

• Patient admitted to a QualityPath hospital

• Admit Type: Elective

• Exclusion Diagnoses are not present

**Index Procedure:** To trigger the bundle, the following elements must be present:

• CPT=27447 (unilateral) or 27447-50(bilateral) or 27447-58 (staged)(Arthroplasty, knee condyle and plateau, medial and lateral compartments)

• CPT=27446 (unilateral) or 27446-50 (bilateral) or 27446-58 (staged) (Arthroplasty, knee, condyle and plateau, medial or lateral compartment)

• Patient has opted to participate in the Quality Path program and has contacted The Alliance prior to the procedure.

**Episode Period**:

• Beginning on the date of admission for the primary procedure and ending 90 days after the surgery date. Outpatient rehabilitation that begins within the Episode Period but continues beyond the 90th day is considered to be included in the Index Procedure.

**Inclusion Diagnosis**: Patient’s primary diagnosis is osteoarthritis

**Exclusion Diagnoses:** Patients with the following diagnoses are not eligible for the bundle:

• Active Cancer

• HIV/AIDS

• End Stage Renal Disease

• Other acquired deformities, lower limb

• Fractures, dislocations and open wounds

• Crushing injury

**Included Services:** The following services are included in the reimbursement for the bundle:

• Inpatient Care- all services billed by the facility during the inpatient period

• Inpatient Professional Services- all services provided by anesthesia/radiology/laboratory/hospitalists/consulting professionals (cardiology, etc.) during the inpatient period

• Surgical Care- charges for the surgeon, assistant surgeon

• Outpatient Rehabilitation- all services related to outpatient rehabilitation (this element may be excluded for patients traveling significant distances for the procedure or for patients seeking Outpatient Rehabilitation services outside of Sauk Prairie Healthcare or Sauk Prairie Healthcare identified providers)

• All services associated with readmissions (see Readmissions below)

• All services associated with complications (see Complications below)

• Radiology charges for treatment of complications during episode period

• Professional fees for treatment of complications during episode period (whether provided by the surgeon or other providers, including ER, anesthesia, and cardiology)

• Facility charges, professional fees and ancillary charges while patient is located in a Sauk Prairie Healthcare or Sauk Prairie Healthcare identified inpatient rehabilitation setting

* Pre-treatment planning, including radiology charges associated with developing a ‘cutting guide’ for the implant

**Services Excluded from the Bundle**: Certain services provided to patients eligible for the bundle reimbursement are not included in the bundle and may be separately reimbursed. These services include:

• Skilled nursing facilities, other than for bilateral knee replacement

• Physical therapy, when PT is not included in the bundle

• Home Health/DME, other than physical therapy provided in the home by Sauk Prairie Healthcare or Sauk Prairie Healthcare identified provider

• Outpatient RX

**Post-operative Complications**: Services related to the treatment of complications during the 90-day episode period are included in the bundle reimbursement and are not separately reimbursed. Examples of potential complications include:

• Wound care, cellulitis, thrombosis, implant failure

Service examples include:

• Joint injections, pain management, X-Ray or MRI, incision and drainage of the knee joint, knee manipulation under anesthesia, removal of knee prosthesis, knee arthroscopy.

**Readmissions:** Hospital readmissions (to the same or system-affiliated facility) resulting from a complication are included in the bundle reimbursement and are not separately reimbursed. Admissions to an acute facility other than the one at which the procedure was performed, or for a condition unrelated to the procedure are not included in the bundle.

 The following MS-DRGs are used to determine a related readmission; the process for handling disputes regarding whether a readmission is related to the Index Procedure is outlined in Section H above

• 175, 176- Pulmonary embolism

• 294, 295- Deep vein thrombosis

• 463, 464, 465- Wound debridement and skin graft, excluding hand, for musculo-connective tissue disorder

• 466, 467, 468- Revision of hip or knee replacement

• 485, 486, 487, 488, 489-Knee procedure with and w/o pdx of infection

• 539, 540, 541- Osteomyelitis

• 553, 554- Bone diseases and arthropathies

• 555, 556- S/Symptoms of musculoskeletal system and conn. tissue

• 559, 560,561- Aftercare, musculoskeletal system and connective tissue

• 564, 565, 566- Other musculoskeletal system and 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 debridement for injuries

• 919, 920, 921- Complications of treatment

• 939, 940, 941- OR procedure with diagnosis of other contact with health services

**Outpatient Rehab**: The inclusion of outpatient rehab services is dependent on whether it is reasonable (or desirable) for the patient to receive rehab services from the provider contracted for the bundle. If the patient is receiving rehab from the provider, the following services are included in the bundle:

• Initial PT evaluation, with recommendation for number of PT visits (generally 1-3 visits per week)

• PT visits, as recommended (PT may be provided in the patient’s home and/or at a physical therapy provider’s location

• Home Health/Occupational therapy evaluation of patient’s home environment and the need for equipment (braces, grab bars, etc.)

* Blood draws for INR for patients receiving anti-coagulant therapy; 2-3x per week for 3 weeks.

**Revisions:** If provided during the episode period, revisions are considered part of the bundle and are not separately reimbursed.

**Revision Procedure CPT Codes**:

• 27486- revision joint total knee arthroplasty w/wo allograft; 1 component

• 27487-revision joint total knee arthroplasty; femoral and entire tibial component

**DRG**

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

**Revision Diagnoses**: All revisions occurring during the 90-day postoperative period are included

 **Total Hip Replacement Bundle**

**Component**: Criteria for Inclusion/Exclusion-Clinician Use

**Overview**: Episodic payment for THR includes all services provided to a “Qualified Patient” during the episode period for:

• Total hip replacement (unilateral, bilateral or staged) for patient with degenerative osteoarthritis (Index Procedure)

• Revision procedure performed during the episode period because of complications associated with the original procedure or for mechanical failure

• Patient complications that arise during the inpatient stay for the index procedure

• Treatment of any complications related to the index or revision procedure, regardless of treatment setting

* Readmission of the patient during the episode period for treatment of complications resulting from the procedure.

**Patient Qualifiers**:

• Patient covered by a QualityPath employer on the date of surgery

• Surgery provided by a QualityPath physician

• Patient admitted to a QualityPath hospital

• Admit Type: Elective

• Exclusion Diagnoses are not present

**Index Procedure**: To trigger the bundle, the following elements must be present:

• CPT 27130, 27130-50 or 27130-58 -Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without autograft or allograft.

• Patient has opted to participate in the QualityPath program and has contacted The Alliance prior to the procedure.

**Episode Period:** Beginning on the date of admission for the primary procedure and ending 90 days after the surgery date.

**Inclusion Diagnosis**: Patient’s primary diagnosis is osteoarthritis

**Exclusion Diagnoses**: Patients with the following diagnoses are not eligible for the bundle:

• Active Cancer

• HIV/AIDS

• End Stage Renal Disease

• Other acquired deformities, lower limb

• Fractures, dislocations and open wounds

• Crushing injury

**Included Services**: The following services are included in the reimbursement for the bundle:

• Inpatient Care- all services billed by the facility during the inpatient period

• Inpatient Professional Services- all services provided by anesthesia/radiology/laboratory/hospitalists/consulting professionals (cardiology, etc.) during the inpatient period

• Surgical Care- charges for the surgeon, assistant surgeon

• Outpatient Rehabilitation- all services related to outpatient rehabilitation (this element may be excluded for patients traveling significant distances for the procedure or for patients seeking Outpatient Rehabilitation services outside of Sauk Prairie Healthcare or Sauk Prairie Healthcare identified providers)

• All services associated with readmissions (see Readmissions below)

• All services associated with complications (see Complications below)

• Radiology charges for treatment of complications during episode period

• Professional fees for treatment of complications during episode period (whether provided by the surgeon or other providers, including ER, anesthesia, cardiology)

* Skilled nursing facility charges associated with bilateral hip replacement only

• Facility charges, professional fees and ancillary charges while patient is located in a Sauk Prairie Healthcare or Sauk Prairie Healthcare identified inpatient rehabilitation setting

* Pre-treatment planning, including radiology charges associated with developing a ‘cutting guide’ for the implant

**Services Excluded from the Bundle**: Certain services provided to patients eligible for the bundle reimbursement are not included in the bundle and may be separately reimbursed. These services include:

• Skilled nursing facilities

• Physical therapy, when PT is not included in the bundle

• Home Health/DME, other than physical therapy provided in the home by Sauk Prairie Healthcare or Sauk Prairie Healthcare identified provider

* Outpatient RX

**Post-operative Complications**: Services related to the treatment of complications during the 90-day episode period are included in the bundle reimbursement and are not separately reimbursed.

Examples of potential complications include:

• Wound care, cellulitis, thrombosis, implant failure

Service examples include:

• Joint injections, pain management, X-Ray or MRI, incision and drainage of the hip joint, dislocation, removal of hip prosthesis

**Readmissions:** Hospital readmissions (to the same or system-affiliated facility) resulting from a complication are included in the bundle reimbursement and are not separately reimbursed. Admissions to an acute facility other than the one at which the procedure was performed are not included in the bundle.

The following MS-DRGs are used to determine a related readmission:

• 175, 176- Pulmonary embolism

• 294, 295- Deep vein thrombosis

• 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 of hip and pelvis

• 537, 538- Sprains strains dislocation hip/pelvis/thigh

• 539, 540, 541- Osteomyelitis

• 553, 554- Bone diseases and arthropathies

• 555, 556- S/Symptoms of musculoskeletal system and connective tissue

• 559, 560,561- Aftercare, musculoskeletal system and connective tissue

• 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 debridement for injuries

• 919, 920, 921- Complications of treatment

* 939, 940, 941- OR procedure with diagnosis of other contact with health services

**Outpatient Rehab**: The inclusion of outpatient rehab services is dependent on whether it is reasonable (or desirable) for the patient to receive rehab services from the provider contracted for the bundle. If the patient is receiving rehab from the provider, the following services are included in the bundle:

• Initial PT eval, with recommendation for number of PT visits (generally 1-3 visits per week)

• PT visits, as recommended (PT may be provided in the patient’s home and/or at a physical therapy provider’s location

• Home Health/Occupational therapy evaluation of patient’s home environment and the need for equipment (braces, grab bars, etc.)

* Blood draws for INR for patients receiving anti-coagulant therapy; 2-3x per week for 3 weeks.

**Revisions:** If provided during the episode period, revisions are considered part of the bundle and are not separately reimbursed.

**Revision Procedure CPT Codes:**

• 27134- Revision of total hip, both components

• 27137- Revision of total hip; acetabular component only

• 27138- Revision of total hip; femoral component only

**DRG**

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

**Revision Diagnoses**: All revisions occurring during the 90-day postoperative period are included