Health Care Payment Improvement

Building a healthier future for all Arkansans

Arkansas Payment Improvement Initiative

Episodes of Care

PRINCIPAL ACCOUNTABLE PROVIDER MANUAL

Hip and Knee Replacement

Episode Reimbursement Program

www.paymentinitiative.org

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Arkansas Blue Plans in this report refers to Arkansas Blue Cross and Blue Shield, Health Advantage and/or BlueAdvantage Administrators of Arkansas.

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Hip and Knee Replacement Episode Reimbursement Program

The Arkansas Health Care Payment Improvement Initiative (AHCPII) was developed as a joint effort between Arkansas Medicaid, QualChoice and Arkansas Blue Cross and Blue Shield, its affiliates and subsidiaries (Arkansas Blue Cross). More information may be found within this manual or at www.paymentinitiative.org.

The **Hip and Knee Replacement** Episode Program will incentivize better coordination of care, encourage clinical effectiveness, and reward high quality care in order to reduce complications that threaten quality and increase costs.

Episode Definition

A core component of this program is episodes of care. An episode is the collection of care provided to treat a particular condition over a given length of time. The hip and knee replacement episode includes all care related to hip and knee total replacement resulting from joint degeneration and osteoarthritis. A hip or knee replacement episode spans from 30 days prior to the surgery to 90 days after index hospitalization discharge date. Included in the episode are all readmissions (applicable per CMS rules) within 30 days, all facility services, inpatient professional services, and rehabilitation services, as well as any related outpatient labs and diagnostics, outpatient costs, and medications.

Principal Accountable Provider (PAP)

For each episode, the provider that holds the main responsibility for ensuring that care is delivered at appropriate cost and quality will be designated as the PAP based on observed patterns of care. The PAP for the hip and knee replacement episode is the surgeon performing the joint replacement surgery. The PAP for each episode is identified retrospectively through claims data. As leaders, however, PAPs will share in the savings and excess costs of episodes. A provider must have five or more eligible cases of an episode to be considered a PAP. For example, a physician must have performed at least five eligible hip replacement episodes or five eligible knee replacement episodes or a combination of the two episodes totaling five or more. The provider billing for the service on the claim is held responsible in the episode calculations and accurate coding is essential.

Claims Submission

Claims filing procedures will be the same as they are today as described in Arkansas Blue Cross' Provider Network Agreements and provider manuals.

Supplemental Quality Measures

In order to participate in upside savings, providers must meet:

1. A quality metric related to the 30-day readmission rate using the same re-admission criteria as CMS.
2. Additionally, PAPs will receive reports highlighting their performance on post-op DVT/PE during inpatient stay and 30-day inpatient readmission and wound infection rate. DVT/PE information about each patient must be entered via the AHIN portal in order for the PAP to participate in sharing any applicable savings.

Adjustments and Exclusions

Reference the Hip and Knee Replacement Algorithm Summary for details.

Reports for Principal Accountable Providers (PAPs)

Reference the AHCPII Overview manual for details and instructions on accessing the PAP Reports on the Provider Portal.

Financial Settlements in the Episodes of Care Model

Reference the AHCPII Overview manual for details on the Financial Settlement Process.

Provider Appeal Process

Reference the AHCPII Overview manual for details on the Provider Appeal Process.

This Program document is referenced in the provider agreements and amendments (defined as ("Program") of the Preferred Payment Plan, True Blue PPO, Arkansas' First Source PPO and Health Advantage Network Participating Provider Agreements. Therefore it is considered to be part of these agreements.

Hip and Knee Replacement Algorithm Summary

Triggers	An episode is triggered when a patient shows an inpatient admission with a DRG for major joint replacement or reattachment of lower extremity w/o MCC with admission and discharge dates surrounding a claim with the surgical CPT procedure code for either total knee arthroplasty or total hip arthroplasty. The patient's claims will also be processed by the OptumInsights ETG software, where they must me assigned an Episode Treatment Group (ETG) for joint degeneration, localized - knee & lower leg if total knee arthroplasty is billed or an ETG for joint degeneration, localized - thigh, hip, & pelvis if total hip arthroplasty is billed. For specific DRG, ICD-9-CM, and CPT/HCPCS procedure codes, please see dataset.
PAP assignment	The Principal Accountable Provider (PAP) for an episode is the orthopedic surgeon enrolled in an Arkansas Blue Plan provider network that performs the total knee arthroplasty or total hip arthroplasty procedure.
Exclusions	Episodes meeting one or more of the following criteria will be excluded: A. The patient has claims or enrollment records that indicate coordination of benefits with another payer not associated with the Arkansas Blue Plans within the duration of the episode B. The patient does not have continuous coverage with at least one Arkansas Blue Plan throughout the entire episode C. The overall episode cost for the patient exceeds the outlier criteria. Currently, the outlier threshold is set at three standard deviations above the average episode cost for all patients otherwise included in the reporting period for all PAPs D. The patient was discharged against medical advice or due to expiration. E. The patient was less than 18 years old at the time of the joint replacement surgery. F. The patient shows bilateral or greater than one total knee and/or total hip replacement surgeries within 120 days of each other, which would have resulted in overlapping episode spans. G. The patient has claims indicating one of the following comorbidities within one year of the episode: 1) HIV; 2) autoimmune disease; 3) end stage renal disease; 4) organ or bone marrow transplant; 5) pregnancy H. The Trigger PAP claim indicates services performed on the opposite side of the body for the Trigger Procedure indicated by Modifier1 'LT' or 'RT' I. Patient is an Exchange member J. Patient is an Access Only member K. Non-par self-insured groups: ABB Inc. (ABB/Baldor and Thomas & Betts), Green Bay Packaging, Hytrol Conveyor Co, Inc, Mana, Nabholz Inc, Navistar Inc, NYSC NYS Holding Company (Nucor), Replacement Parts, Riceland Foods Inc, Southern Steel & Wire (effective 1/1/16), and White River Medical Center
Episode time window	Episodes begin 30 days prior to the joint replacement surgical procedure and conclude 90 days after the discharge for the inpatient stay in which the surgery was performed. Comorbidities are assessed within the same calendar year as the episode.
Claims included	The following services are included if incurred within the episode: A. All claims within 30 days prior to the surgery and 90 days after discharge from the inpatient stay for the surgery identified by the appropriate ETG for joint degeneration, localized - knee & lower leg or joint degeneration, localized - thigh, hip, & pelvis. B. All claims for inpatient admissions within 30 days after the discharge from the inpatient stay for the surgery. Claims with a DRG on the CMS list of exclusions for major joint replacement of lower extremity will not be included in the episode. C. All claims for anesthesia for the total knee or total hip arthroplasty if not otherwise captured by the ETG.

Quality measures	*Quality measures "to pass" (payment related):* A. There are currently no measures linked to Gain Sharing. *Quality measures "to track" (not payment related):* A. 30 day all cause readmission rate. B. 30 day wound infection readmission rate C. Rate in which deep vein thrombosis and pulmonary embolism prophylaxis is prescribed during the inpatient stay for total episodes included. This is based on entry in the provider portal indicating that a post-operative DVT/PE prophylaxis (pharmacologic or mechanical compression) was prescribed during the inpatient stay. D. Rate in which the patient developed a symptomatic post-operative deep vein thrombosis or pulmonary embolism during the inpatient stay for total episodes included. This is based on entry in the provider portal indicating that the patient developed a symptomatic post-operative deep vein thrombosis or pulmonary embolism during the inpatient stay.
Utilization measures	No utilization measures are tracked for total knee and total hip replacement episodes.
Adjustments	No adjustments are made to claim costs after all exclusions have been applied.
Trigger codes	Claims with following DRG codes are considered when triggering an episode: **MS-DRG:** 470 Claims with following CPT procedure codes are considered when triggering an episode: **Procedure codes:** 27447, 27130, 27132
Exclusion codes	Patients who have co-morbid condition(s) matching the following ICD-9-CM codes will be excluded: **ICD-9-CM codes:** 042.xx, 279-279.09, 585.5, 585.6, 630-669.94, 996.8, V22-V24.99, V27-V27.9, V42.0, V42.1, V42.5, V42.7, V42.81, V45.1, V56.xx Claims with the following DRG codes are excluded: **MS-DRG codes**: 0638 Claims with the following DRG codes are excluded based on the CMS exclusions for major joint replacement of lower extremity: **MS-DRG codes:** 001, 002, 005, 006, 007, 008, 010, 011, 012, 013, 014, 016, 017, 020, 021, 022, 023, 024, 025, 026, 027, 028, 029, 030, 031, 032, 033, 037, 038, 039, 040, 041, 042, 113, 114, 115, 116, 117, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 163, 164, 165, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 237, 238, 242, 243, 244, 245, 258, 259, 260, 261, 262, 263, 264, 265, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344,

Exclusion codes continued	Claims with the following DRG codes are excluded based on the CMS exclusions for major joint replacement of lower extremity: **MS-DRG codes:** 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 453, 454, 455, 456, 457, 458, 459, 460, 471, 472, 473, 490, 491, 506, 507, 508, 510, 511, 512, 513, 514, 582, 583, 584, 585, 614, 615, 619, 620, 621, 625, 626, 627, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 765, 766, 767, 768, 769, 770, 799, 800, 801, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 876, 906, 927, 928, 929, 955, 956, 957, 958, 959, 969, 970, 984, 985, 986 **Please see the final pages of this document for a list of the corresponding ICD-10 codes**
Claims included codes	Claims with the following DRG code for the surgical inpatient stay are included in the episode: **MS-DRG:** 470 Claims with the following CPT procedure codes are included when performed within the surgical stay: **Procedure codes:** 01402, 01214, 27447, 27130, 27132 In addition, the episode will include all claims classified with an ETG of joint degeneration, localized - knee & lower leg, if total knee arthroplasty is billed, or an ETG of joint degeneration, localized - thigh, hip, & pelvis, if total hip arthroplasty is billed, with services dates within 30 days prior to the surgical procedure and 90 days after discharge from the surgical inpatient stay.
Quality codes	Inpatient facility claims with the following ICD-9 diagnosis codes will determine whether an episode has a readmission related to wound infection: **ICD-9-CM codes:** 686, 686.0, 686.00, 686.01, 686.09, 686.1, 686.8, 686.9, 916.9, 958.3, 996.6, 996.66, 996.67, 996.69, 998.5, 998.51, 998.59, 995.91, 995.92 **Please see the final pages of this document for a list of the corresponding ICD-10 codes**
Utilization codes	No utilization measures are tracked for total knee and total hip replacement episodes.

Exclusion codes	Patients who have co-morbid condition(s) matching the following ICD-10-CM codes will be excluded: **ICD-10-CM codes:** 005F0ZZ, 005F3ZZ, 005F4ZZ, 005G0ZZ, 005G3ZZ, 005G4ZZ, 005H0ZZ, 005H3ZZ, 005H4ZZ, 005J0ZZ, 005J3ZZ, 005J4ZZ, 005K0ZZ, 005K3ZZ, 005K4ZZ, 005L0ZZ, 005L3ZZ, 005L4ZZ, 005M0ZZ, 005M3ZZ, 005M4ZZ, 005N0ZZ, 005N3ZZ, 005N4ZZ, 005P0ZZ, 005P3ZZ, 005P4ZZ, 005Q0ZZ, 005Q3ZZ, 005Q4ZZ, 005R0ZZ, 005R3ZZ, 005R4ZZ, 005S0ZZ, 005S3ZZ, 005S4ZZ, 01500ZZ, 01503ZZ, 01504ZZ, 01520ZZ, 01523ZZ, 01524ZZ, 01530ZZ, 01533ZZ, 01534ZZ, 01540ZZ, 01543ZZ, 01544ZZ, 01550ZZ, 01553ZZ, 01554ZZ, 01560ZZ, 01563ZZ, 01564ZZ, 01590ZZ, 01593ZZ, 01594ZZ, 015A0ZZ, 015A3ZZ, 015A4ZZ, 015C0ZZ, 015C3ZZ, 015C4ZZ, 015D0ZZ, 015D3ZZ, 015D4ZZ, 015F0ZZ, 015F3ZZ, 015F4ZZ, 015G0ZZ, 015G3ZZ, 015G4ZZ, 015H0ZZ, 015H3ZZ, 015H4ZZ, 015Q0ZZ, 015Q3ZZ, 015Q4ZZ, 3E0T3TZ, 3E0X3TZ, B20, 0CC00ZZ, 0CC03ZZ, 0CC10ZZ, 0CC13ZZ, 0CC40ZZ, 0CC43ZZ, 0CN0XZZ, 0CN1XZZ, 0CPY00Z, 0CPY01Z, 0CPY07Z, 0CPY0DZ, 0CPY0JZ, 0CPY0KZ, 0CPY30Z, 0CPY31Z, 0CPY37Z, 0CPY3DZ, 0CPY3JZ, 0CPY3KZ, 0CWY00Z, 0CWY01Z, 0CWY0DZ, 0CWY0JZ, 0CWY0KZ, 0CWY30Z, 0CWY31Z, 0CWY37Z, 0CWY3DZ, 0CWY3JZ, 0CWY3KZ, 0WC30ZZ, 0WC33ZZ, 0WC34ZZ, 0WH303Z, 0WH30YZ, 0WH333Z, 0WH33YZ, 0WH343Z, 0WH34YZ, D800, D801, D802, D803, D804, D805, D806, D807, D808, D809, D810, D811, D812, D814, D816, D817, D8189, D819, D820, D821, D822, D823, D824, D828, D829, D830, D831, D832, D838, D839, D840, D848, D849, D893, D89810, D89811, D89812, D89813, D8982, D8989, D899, Z331, Z3400, Z3401, Z3402, Z3403, Z3480, Z3481, Z3482, Z3483, Z3490, Z3491, Z3492, Z3492, O0900, O0901, O0902, O0903, O0910, O0911, O0912, O0913, O09211, O09212, O09213, O09219, O09291, O09292, O09293, O09299, O0930, O0931, O0932, O0933, O0940, O09519, O09529, O09611, O09612, O09613, O09619, O09621, O09622, O09623, O09629, O0970, O0971, O0972, O0973, O09811, O09812, O09813, O09819, O09821, O09822, O09823, O09829, O09891, O09892, O09893, O09899, O0990, O0991, O0992, O0993, O3680X0, O3680X1, O3680X2, O3680X3, O3680X4, O3680X5, O3680X9, Z390, Z391, Z392, Z370, Z371, Z372, Z373, Z374, Z3750, Z3751, Z3752, Z3753, Z3754, Z3759, Z3760, Z3761, Z3762, Z3763, Z3764, Z3769, Z377, Z379, Z4901, Z4902, Z4931, Z4932
Quality codes	Inpatient facility claims with the following ICD-10 diagnosis codes will determine whether an episode has a readmission related to wound infection: **ICD-10-CM codes:** B781, D0Y08ZZ, D0Y18ZZ, D0Y68ZZ, D0Y78ZZ, D7Y08ZZ, D7Y18ZZ, D7Y28ZZ, D7Y38ZZ, D7Y48ZZ, D7Y58ZZ, D7Y68ZZ, D7Y78ZZ, D7Y88ZZ, D8Y08ZZ, D9Y08ZZ, D9Y18ZZ, D9Y38ZZ, D9Y48ZZ, D9Y58ZZ, D9Y68ZZ, D9Y78ZZ, D9Y88ZZ, D9Y98ZZ, D9YB8ZZ, D9YD8ZZ, D9YF8ZZ, DBY08ZZ, DBY18ZZ, DBY28ZZ, DBY58ZZ, DBY68ZZ, DBY78ZZ, DBY88ZZ, DDY08ZZ, DDY18ZZ, DDY28ZZ, DDY38ZZ, DDY48ZZ, DDY58ZZ, DDY78ZZ, DFY08ZZ, DFY18ZZ, DFY28ZZ, DFY38ZZ, DGY08ZZ, DGY18ZZ, DGY28ZZ, DGY48ZZ, DGY58ZZ, DHY28ZZ, DHY38ZZ, DHY48ZZ, DHY68ZZ, DHY78ZZ, DHY88ZZ, DHY98ZZ, DHYB8ZZ, DMY08ZZ, DMY18ZZ, DPY08ZZ, DPY28ZZ, DPY38ZZ, DPY48ZZ, DPY58ZZ, DPY68ZZ, DPY78ZZ, DPY88ZZ, DPY98ZZ, DPYB8ZZ, DPYC8ZZ, DTY08ZZ, DTY18ZZ, DTY28ZZ, DTY38ZZ, DUY08ZZ, DUY18ZZ, DUY28ZZ, DVY08ZZ, DVY18ZZ, DWY18ZZ, DWY28ZZ, DWY38ZZ, DWY48ZZ, DWY58ZZ, DWY68ZZ, E832, K6811, L080, L0881, L0882, L0889, L089, L88, L928, L980, R6520, T814XXA, T8450XA, T8451XA, T8452XA, T8453XA, T8454XA, T8459XA, T8460XA, T84610A, T84611A, T84612A, T84613A, T84614A, T84615A, T84619A, T84620A, T84621A, T84622A, T84623A, T84624A, T84625A, T84629A, T8463XA, T8469XA, T847XXA, T8572XA, T8579XA, T86842