



TOTAL JOINT REPLACEMENT (HIP & KNEE) EPISODE

Overview of a total joint replacement (Hip & Knee) episode

The total joint replacement episode revolves around an individual undergoing an elective hip or knee replacement. This episode is triggered by the joint replacement procedure, the primary purpose of which is to treat chronic arthritis of the hip or knee. The start date of the episode is 45 days prior to admission, and includes only claims related to the total joint replacement. Following discharge from the hospital, care associated with the joint replacement such as physical therapy and certain medications are included in the episode, as are complications related to the procedure like infections, blood clots, and readmissions for up to 90 days after discharge.

Sources of Value

In treating patients with chronic arthritis of the hip and knee health care providers have multiple opportunities to improve the quality and cost of care. For example, ordering appropriate testing during the pre-operative period, following meticulous surgical technique, utilizing appropriate perioperative precautions and medications, and timely discharge from the hospital can all reduce the likelihood of complications such as blood clots and infection requiring readmission. These improved outcomes also lead to cost effective care.

Principal Accountable Provider

The Principal Accountable Provider (also referred to as the Quarterback) of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the Quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the total joint replacement episode, the Principal Accountable Provider is the orthopedic surgeon who performs the procedure. All Principal Accountable Providers will receive reports according to their tax ID number.

Claim exclusions and risk adjustment

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete, and
- Risk adjusting to account for the cost of more complicated patients.

Examples of exclusion criteria specific to the total joint episode include a patient who undergoes a traumatic injury or has an unrelated medical event such as a myocardial infarction in the immediate postoperative period.

Other exclusions apply to any type of episode, i.e., are not specific to a joint replacement episode. For example, an episode would be excluded if more than one payer was involved in covering a single episode of care, the patient was not continuously insured by the payer between the day of the earliest claim included in the episode and the end of the episode or the patient had a discharge status of “left against medical advice”.

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For the purposes of determining a Principal Accountable Provider's cost for each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk and/or severity factors captured in recent claims data in order to be fair to providers caring for more complicated patients. A few examples of total joint replacement episodes with factors likely to be impacted by risk adjustment include those patients with history of diabetes mellitus, obesity, or rheumatoid arthritis. Over time, a payer may add or subtract risk factors in line with new research and/or empirical evidence. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs. The final risk adjustment methodology decisions will be made at the discretion of the payer after analyzing the data.

Quality metrics

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A Principal Accountable Provider must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Quality metrics tied to gain sharing are referred to as threshold metrics. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The threshold quality metrics for the total joint replacement episode (i.e. the quality metrics tied to gain sharing) are: the readmission rate in the 30 day period following discharge from the hospital. The quality metrics that will be tracked and reported to providers but that are not directly tied to gain sharing are: the rate of patients who have a post-operative deep vein thrombosis or pulmonary embolism within 30 days after surgery, the average wound infection rate within 90 days after surgery, the average dislocation or fracture rate within 90 days after surgery, and the average length of stay in the hospital.

It is important to note that quality metrics are calculated by each payer on a per Principal Accountable Provider basis across all of a Principal Accountable Provider's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a Principal Accountable Provider ineligible for gain sharing with that payer for the performance period under review.