HEALTH PLAN and HOSPITAL ADDENDUM TO PPO AGREEMENT

THIS BUNDLED PAYMENT ADDENDUM (this "Addendum") is made and entered into by and between _____, a ("Plan"), and _____, a California _____ ("Provider"), as of _____, 20__. (Plan and Provider are referred to herein individually as a "Party" and collectively as the "Parties").

This Addendum sets forth the terms and conditions under which Provider will participate in a bundled payment arrangement ("Bundled Payment Program"). Pursuant to the Bundled Payment Program, Provider has contracted with other providers to accept one case rate from Plan for specified services, which include both hospital and post-acute services.

This Addendum effective date ("Bundled Payment Addendum Effective Date") is listed below and binds this Addendum to the Parties' **[**PPO Agreement**]** dated _____ (the "Agreement"). This Addendum shall have a term coterminous with Agreement.

Bundled Payment Addendum Effective Date: _____.

A. INTRODUCTION

The intent of the Parties is that the negotiated bundled episode payment should include all *Covered Services* provided to a *Covered Person* during the *Episode Period* for:

1. An *Index Procedure* of total knee or total hip replacement for patient with degenerative osteoarthritis;

2. Routine Care appropriate to the Index Procedure; and

3. Patient Complications arising during the stay for *Index Procedure* or during the *Episode Warranty Period* following the surgery, *Included Readmissions* and *Revision Procedures* performed during the Episode Period because of complications associated with the original procedure or for mechanical failure.

Provider and Plan may mutually agree to include an optional rehabilitation package for an additional negotiated fee.

B. DEFINITIONS

1. ***Covered Services*** The following services are included in the episode definition and negotiated episode payment. They may not be separately billed by Provider when treating a Covered Person during the Episode Period.

- During the *Episode Period,* and for any included *Readmission*, Covered Services include:

    - All physicians, anesthesiologists, other attending and consulting physicians fees, beginning with the day of surgery;

    - Preoperative visits after the decision is made to operate;

- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical pain management by the surgeon;
- Supplies, except for those identified as exclusions;
- Miscellaneous Services (items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes);
- All other medically necessary services and supplies;
- All inpatient and outpatient professional services;
- All services provided by Provider or its contracting providers under the Bundled Payment Program.

- During the *Episode Warranty Period* (including *Readmission*), Covered Services include:
  - All Covered Services above: outpatient institutional and professional follow-up care, consultations, and related services, including but not limited to medical care, or similar services; and
  - All other related episode covered services will be included unless they are clearly caused by injury or disease other than the underlying disease for which the Index Procedure is being undertaken. For example, injuries due to an automobile accident or disease unrelated to the diagnosis of degenerative osteoarthritis (for example, primary care or specialist visits for a dermatologic condition).

- Covered Services do NOT include the following:
  - The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;
  - Outpatient prescription drugs;
  - Professional charges for treatment in a skilled nursing facility;

- Outpatient services clearly unrelated to the Index Procedure or underlying condition, for example, pregnancy or, for osteoarthritis treatment, surgical evaluation and planning for a procedure on a different joint than the one on which the Index Procedure was performed (knee replacement on the other leg); and

- Inpatient services not provided during the admission for the Index Procedure or an Included Readmission (for example, admission for an appendectomy).

2. Episode Period

- The Episode Period begins on the date of admission for the Index Procedure and continues to the 90th day following the date of the original admission.

- Readmissions (as defined) that begin within the Episode Period are included in the episode price (may not be separately billed), even if the period of readmission extends beyond 90 days following the date of the original admission. For example, if a patient were readmitted for a surgical site infection on the 89th day of the Episode Period, the Episode Period would be extended until that patient is discharged.

- Covered Persons who elect to have a second Index Procedure (i.e., total knee replacement on the other knee) during the first Episode Period, begin a new 90-day Episode Period on the date of admission for the second surgery.

- For purposes of determining Covered Services, the Episode Period is divided into:

  - The *acute period* begins on the date of admission to Provider or its partner hospital under the Bundled Payment Program for the Index Procedure and continues to the date of discharge from Provider or its partner hospital for the Index Procedure.

  - The *warranty period* begins on the date of discharge from Provider or its partner hospital for the Index Procedure and continues through the 90th day following date of admission for the Index Procedure.

  - The *rehabilitation period* (only for participants contracting for the optional rehabilitation package) begins on the date of discharge for the Index Procedure and continues through the 21st day following discharge for the Index Procedure.

3. Readmissions

For purposes of the Bundled Payment Program, a Readmission is defined to mean any subsequent admission to an acute care facility that occurs within the Episode Period. However, whether a Readmission is included in the contracted episode rate (and thus may not be separately billed) depends on: a) the facility where the patient is readmitted, and b) whether the readmission is considered to have been caused by or related to the Index Procedure (according to rules below).

- Provider agrees that Covered Persons will be readmitted to the applicable hospital (i.e., the hospital participating under the Bundled Payment Program (the "Participating Hospital")) except when: the Covered Person requires emergency admission to a closer facility, the Covered Person requires care that cannot be provided at the Participating Hospital, or the Covered Person refuses to be readmitted to the Participating Hospital.

- A readmission at to the Participating Hospital is assumed to be related to the Index Procedure and is included in the episode price (may not be separately billed) if the readmission groups to one of the defined set of DRGs below.

Defined DRGs for Index Procedure of Total Knee Replacement

- 175, 176—Pulmonary 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
- 485, 486, 487, 488, 489—Knee Procedures with and without pdx of Infection
- 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 (note: these DRGs are included only if septicemia is related to a septic joint or central line infection)
- 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

Defined DRGs for Index Procedure of Total Hip Replacement

- 175, 176—Pulmonary 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 (note: these DRGs are included only if septicemia is related to a septic joint or central line infection)
- 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

4. Index procedures

The tables below outline the primary procedure codes (i.e., are in the primary position on the billing code) that will trigger the provisions of this Addendum. Revision procedures other than those occurring within 90-days of an Index Procedure for a Covered Person participating in this Program are also excluded.

Definition of Total Knee Replacement Index Procedure		
Index Procedure Code: This procedure must exist to trigger the episode. CPT: ▪ 27447—Arthroplasty, knee condyle and plateau, medical and lateral compartments ICD-9 Px: ▪ 81.54—Total Knee replacement	**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
Definition of Total Hip Replacement 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

5. Optional rehabilitation package

If the Parties agree, the episode may include an optional package of rehabilitation services that will be provided during the *rehabilitation period* (defined above under *Episode Period)*. This package will include*:*

- Initial evaluation by a physical therapist, including development of a recommended physical therapy plan;
- All physical therapy visits provided during the *rehabilitation period*;
- Evaluation by a home health aide or occupational therapist of the Covered Person's physical environment and need for durable medical equipment; and
- All home health visits and/or blood draws to calculate the international normalized ratio (INR) for Covered Persons receiving anti-coagulant therapy provided during the *rehabilitation period.*

6. Covered Person

For inclusion in the Bundled Payment Program, a patient must be:

- Undergoing surgery provided by an orthopedic surgeon contracting directly or indirectly with Plan to provide services under the Bundled Payment Program;
- Admitted to the Participating Hospital under the Bundled Payment Program to provide specified services under the Participating Hospital's applicable payor agreement;
- Presenting for the Index Procedure with an American Society of Anesthesiologists (ASA) rating of <3 (and post-discharge assignment to APR-DRG SOI level of 1 or 2);
- Presenting for the Index Procedure without:
  - Clinical history that demonstrates a clinical condition of active cancer, HIV/AIDS, or End Stage Renal Disease
  - Body Mass Index (BMI) of 40 or greater;
- Over age 18 and under age 65 on the date of surgery; and
- Covered (as primary plan) by a participating employer and health plan on date of surgery.

7. Patient complications

All Covered Services provided to treat patient complications that arise during the Episode Period are included in the negotiated episode rate, and may not be separately billed through the end of Episode Period. Examples of complications include patients with infections, wound issues or cellulitis. Service examples include: joint injection, pain management, X-Ray or MRI, dislocation, incision and drainage of hip joint, removal of hip prosthesis. (All outpatient services after the end of the Episode

Period will be excluded from Covered Services; e.g. treatment for infections that continues for 12 months. However, all costs of an included readmission that begins within the Episode Period even if the readmission extends beyond the 90-day window will be included as a Covered Service).

8. Revision Procedures

Revision procedures are included in the episode payment only if performed within the 90-day Episode Period as a result of patient complications or device failure.

Revision Procedures for Knee Replacement		
Procedure Code These procedure codes constitute a covered revision if performed within 90-days of Index Procedure CPT: • 27486—Revision joint total knee arthroplasty with or without allograft 1 component • 27487—Revision joint total knee arthoplasty fem and entire tibl component ICD-9 Px: ▪ 00.80—Revision of knee repl, total (all components) ▪ 00.81—Revision of knee repl, tibial component ▪ 00.82—Revision of knee repl, femoral component 00.83—Revision of knee replacement, patellar component ▪ 00.84—Revision of knee replacement, tibial insert (linear) ▪ 81.55—Revision of knee replacement, NOS	**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 bundle for the Index Procedure.**	**Included Diagnoses:** ▪ All

Revision Procedures for Hip Replacement		
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	**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 bundle for the Index Procedure.**	**Included Diagnoses:** ▪ All

▪ 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		

9. Routine care appropriate to the Index Procedure

This includes:

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- Supplies (except for those identified as exclusions and Miscellaneous Services) - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes; and
- Diagnostic tests and procedures, including diagnostic radiological procedures.

C. REFERRALS AND PROVIDER QUALIFICATION CRITERIA

1. Patient Referral

Once a patient is identified as a qualified candidate for the Bundled Payment Program, Provider will follow the authorization requirements as described in the Agreement.

2. Qualification Criteria

Provider must at all times meet Plan's qualification criteria for Bundled Payment Program participation.

D. PAYMENT TERMS

1. General Payment Terms

For the provision of Covered Services to a patient, Plan will pay Provider under the terms of this Addendum, subject to any benefit plan limitations as described in the Parties' Agreement. The obligation for payment under this Addendum is solely that of Plan. Provider will accept as payment in full for Covered Services rendered the total of amounts payable by Plan pursuant to this Agreement, plus allowed patient charges pursuant to the terms of the Agreement, as may be amended.

2. The Case Rate Payment

Claims for Covered Services included in the case rate for the Episode Period will be paid to Provider at _____ and will be paid pursuant to Section D.3 below. Provider and its provider affiliates under the Bundled Payment Program will look solely to Plan for payment of all Covered Services rendered pursuant to this Agreement. This Addendum shall not apply to any services, including, without limitation, Covered Services that are the financial responsibility of a third party that is not a Plan under this Agreement.

a) Price: Knee (with or without optional rehab package)
b) Price: Hip (with or without optional rehab package)
c) Stop loss or catastrophic claim provisions if any

3. Payment Schedule

For cases paid pursuant to the Bundled Payment Program, Provider will bill the Plan for the full bundled amount no more than sixty (60) days from the date that the applicable Covered Person was discharged from the Participating Hospital for the Index Procedure. Plan will pay Provider within 30 days after receipt of the claim. Notwithstanding the foregoing, in addition to the claim above, Provider shall submit to the Plan a Final Claim at the end of the Episode Period for purposes of data reporting only. For purposes of this Section D.3., a "Final Claim" means an invoice, reasonably detailed, that illustrates all health care services provided to the Covered Person pursuant to the Bundled Payment Program during the Episode Period.

4. Refunds

Provider will refund any overpayment to Plan within 30 days of Provider's receipt of a notice from Plan, if such overpayment is not a disputed amount. In the event that the overpayment is disputed, the Parties will resolve such dispute pursuant to the terms of the Agreement.

5. Late Payment Penalty

If payment is not received by Provider within 30 days from the date Plan receives a claim from Provider, Plan shall pay Provider interest at a rate of one and one-half percent (1.5%) on any unpaid balance each month the balance is overdue. Provider will make best efforts to notify Plan in writing of its intent to assess this late payment penalty.

6. Referrals to Non-Participating Providers

In the event that a Participating Hospital or other provider under the Bundled Payment Program refers a Covered Person to another facility or provider not participating in the Bundled Payment

Program (collectively, "Non-Participating Providers") during the Episode Period, and the Participating Hospital or other provider intends to continue treating such Covered Person and

does not relinquish ultimate responsibility for such Covered Person's care, the payment for Covered Services provided by the Non-Participating Providers during the Episode Period will be the responsibility of Provider, and such amount will be included in the bundled payment made to Provider by Plan, and no additional payments will be made from Plan to Provider to cover such expense.

7. Premature Closure of Case

No bundled payments will be made, and the payment terms under the Agreement will control, if:

- A Covered Person loses coverage with Plan during the Episode Period for any reason (e.g., due to death, becoming covered by Medicare, employer switching health plans.); or
- A Covered Person is transferred or referred to a Non-Participating Provider without the expectation that such Covered Person will return to the Participating Hospital or other provider at any time during the Episode Period.

Note that readmission to a hospital other than the Participating Hospital during the Episode Period does not constitute a reason for premature closure of the case. Under such circumstances, a bundled payment will still be made to Provider pursuant to the terms of this Addendum. Except as set forth under Section 6 above, Provider assumes no liability for payments that may be due to Non-Participating Providers under the Plan's contract with such Non-Participating Providers or the Covered Person's benefit plan.

Additionally, the case will not be subject to premature closure if the Covered Person leaves the Participating Hospital or otherwise discontinues treatment during the Episode Period "against medical advice."

E. MISCELLANEOUS PROVISIONS

1. Quality Improvement

Provider agrees to participate and cooperate with Plan and others as desirable or appropriate for purposes of furthering quality improvement and reporting processes as developed for the Bundled Payment Program (e.g., quality measure development and reporting, patient education and/or shared-decision making processes). These processes will not include public reporting of quality information unless such reporting is mutually agreed upon in advance by Provider.

2. Grievance Procedure

The grievance procedure outlined in the Agreement will apply to the processing of any patient complaint regarding Covered Services furnished by Provider.

3. Coordination of Benefits

Provider agrees to coordinate with Plan for proper determination of the coordination of benefits and to bill and collect from other payors such charges for which the other payor is responsible. Such coordination is intended to preclude Provider from receiving or a Covered Person from paying an aggregate of more than one hundred percent (100%) of the rates set forth in this Addendum for Covered Services.

4. Continuation of Services

Upon any termination of this Addendum and Provider's participation in the Bundled Payment Program, Provider, at Plan's request, shall remain obligated to furnish those Covered Services that Provider is qualified to provide to any Covered Person under Provider's care at the time of termination; however, compensation for such services provided after the termination of this Addendum shall be pursuant to the Agreement, and not this Addendum.

5. Effect of Addendum

This Addendum and associated Agreement supersede any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.
As to any particular patient who has accessed Provider for Covered Services under the terms of a prior agreement, the terms of that prior agreement will continue to apply to that patient's care through the duration of treatment for which terms are included under the prior agreement.

IN WITNESS WHEROF, the Parties have executed this ADDENDUM on the dates set forth below opposite their respective names.

"PLAN"	"PROVIDER"
By _____ (Signature)	By _____ (Signature)
_____ (Printed Name)	_____ (Printed Name)
Title _____ Date _____	Title _____ Date _____

**This project was supported by grant number R18HS020098 from the Agency for Healthcare Research and Quality. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality.*