Alberta Health and Wellness

Bulletin

Alberta Health Care Insurance Plan

Number: Med Special Edition to General Practitioners	**Date:** April 6, 2009	**Page:** 1 of 1
Subject: Comprehensive Annual Care Plans for patients with complex needs	**Reference:** Bulletin Med 141	

As described in Bulletin Med 141, health service code (HSC) 03.04J was implemented in the Schedule of Medical Benefits (SOMB) effective April 1, 2009 with the following description:

> Development, documentation and administration of a comprehensive annual care plan for a patient with complex needs.

The attachment to this Bulletin provides detailed information that:

- defines a Comprehensive Annual Care Plan;
- lists benefits of Comprehensive Annual Care Plans for patients, physicians and the Health System;
- provides the full text of 03.04J;
- lists diagnostic codes to be used in preparing claims for 03.04J;
- provides a sample template, which may be used by physicians to create a care plan; and
- answers frequently asked questions about 03.04J.

As described in Note 3 under 03.04J, this service may be claimed in addition to 03.04K, which is also effective April 1, 2009. HSC 03.04K is used to submit claims for performing annual geriatric assessments. A full description of 03.04K is provided in both Bulletin Med 141 and the April 1, 2009 SOMB.

However, 03.04J is restricted to facility type OFFC (office) or HOME, while 03.04K may only be claimed when performed in a regional facility. Therefore, payment for 03.04J and 03.04K on the same date of service will not be made unless the correct facility codes appear on the claims. Future amendments will be made to the Schedule of Medical Benefits to further clarify the billing rules for 03.04J and 03.04K.

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Comprehensive Annual Care Plan

A fee-for-service model to compensate physicians for coordination of the comprehensive care of patients with complex medical needs

Table of Contents

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Introduction

Albertans living with multiple co-morbidities encounter considerable challenges in navigating the health care system and successfully meeting their health needs. The care of patients with complex conditions often involves a number of different health providers and is time-consuming and demanding. Generally the patient's general practitioner takes on the role of coordinating the health care processes involved. Alberta Health and Wellness has created a new Fee for Service (FFS) model to formalize the process of creating a Comprehensive Annual Care Plan for patients with multiple co-morbidities. It will compensate physicians for the time and effort involved in the development, documentation and administration of Comprehensive Annual Care Plans and coordination of the health care services the patient needs.

Comprehensive Annual Care Plan

A Comprehensive Annual Care Plan is a single document that includes important information on a patient's current therapies, health challenges, medical history, information about other health care providers involved in the patient's care, and other relevant information that may affect the patient's health or treatment options.

The Comprehensive Annual Care Plan must include clearly defined goals, which have been mutually agreed on by the patient and/or the patient's agent, and the physician. The Comprehensive Annual Care Plan is prepared in collaboration with the patient so it can take into account the patient's values and personal health goals as they relate to his or her complex health care needs.

The Comprehensive Annual Care Plan must be signed by the physician and the patient and/or the patient's agent. A copy of the Plan must be given to the patient and a copy must be placed in the patient's file.

Benefits of the Care Plan

Benefits to the Patient

The Comprehensive Annual Care Plan will:

- Help patients better understand and manage their complex medical conditions.
- Help patients navigate through the health care system.
- Improve the patient's access to a team of health care professionals.
- Serve as a self-management tool to help patients create and achieve short and long term goals as they manage their chronic health conditions.

Benefits to the Physician

The creation of a Comprehensive Annual Care Plan will:

- Facilitate the remuneration of physicians for the time and effort required to properly manage patients with complex conditions.
- Assist in the coordination and overall management of good patient care.
- Improve communication between patients and their primary care physician.
- Improve and enhance collaboration among multiple health practitioners.

Benefits to the Health System

The implementation of the new health service code will:

- Shift emphasis from episodic care to the more comprehensive, coordinated care required by eligible patients.
- Improve patient care and service delivery by potentially improving access to multiple health practitioners.
- Provide the remuneration to support the continued development of chronic disease management and primary care strategies currently underway in Alberta.

The New HSC (03.04J)

03.04 J Development, documentation and administration of a Comprehensive Annual Care Plan for a patient with complex needs

NOTE:

1. May only be claimed by the most responsible primary care general practitioner.
2. May only be claimed once per patient per year and includes ongoing communication as required as well as re-evaluation and revision of the plan within that year.
3. May be claimed in addition to HSCs 03.03A, 03.03N, 03.04A or 03.04K.
4. Time spent on the preparation of the Comprehensive Annual Care Plan may not be included in the time requirement for a complex modifier.
5. "Complex needs" means a patient with multiple complex health needs including chronic disease(s) and other complications. The patient must have at least two or more diagnoses from group A or one diagnosis from group A and one or more from group B in order to be eligible.

Group A	Group B
• Hypertensive Disease	• Mental Health Issues
• Diabetes Mellitus	• Obesity
• Chronic Obstructive Pulmonary Disease	• Addictions
• Asthma	• Tobacco
• Heart Failure	
• Ischaemic Heart Disease	

6. "Comprehensive Annual Care plan" means a single document that meets the following criteria:
   a) Must be communicated through direct contact with the patient and/or the patient's agent (agent as defined in the Personal Directives Act (RSA 2007c37s3)).

   b) Must include clearly defined goals which are mutually agreed upon between the patient and/or the patient's agent and the physician.

c) Must include a detailed review of the patient's chart, current therapies, health challenges and past medical history.
d) Must include any relevant information that may affect the patient's health or treatment options, such as demographics (education, income, language, etc.) or lifestyle behaviors (addictions, exercise, sleep habits, etc.)
e) Must incorporate the patient's values and personal health goals in the Comprehensive Annual Care Plan, with respect to his or her complex needs.
f) Must outline expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate.
g) Must identify other health care professionals that would be involved in the care of the patient and their expected roles.
h) Must include confirmation that the Comprehensive Annual Care Plan has been communicated verbally and in writing to the patient.
i) Must be signed by the physician and the patient and/or the patient's agent.

List of Applicable Diagnostic Codes

Following the International Classification of Diseases (ICD)-9 listing of Diagnostic Codes, a claim for HSC 03.04J must include one diagnostic code from column A and one diagnostic code from column B, or two diagnostic codes from A. In order for the claim to be paid, these specific diagnostic codes must be on the claim in any of the three diagnostic code fields available. A third diagnostic code may also be included but is not necessary for payment.

All subsets of the listed ICD codes are also relevant. For example, 493.0, 493.1 and 493.9 are all acceptable for asthma.

Column A		Column B	
Hypertensive Disease	(ICD 401)	Mental Health Issues	(ICD 290-319)
Diabetes Mellitus	(ICD 250)	Obesity	(ICD 278)
Chronic Obstructive Pulmonary Disease	(ICD 496)	Addictions	(ICD 303-304)
Asthma	(ICD 493)	Tobacco	(ICD 305.1)
Heart Failure	(ICD 428)		
Ischaemic Heart Disease	(ICD 413-414)		

Sample Comprehensive Annual Care Plan

Adobe Reader 7.0+ is required to complete & save this document.

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Comprehensive Annual Care Plan

Patient's Name _____ Date *(mm/dd/yyyy)* _____

Affix label here

Part 1 - Diagnoses

"Complex" patient means multiple complex health needs including chronic disease and other complications. The patient must have at least two diagnoses from Group A OR at least one from Group A and one from Group B.

GROUP A	GROUP B
☐ Hypertensive disease (401)	☐ Mental Health (290-319)
☐ Diabetes Mellitus (250)	☐ Obesity (278)
☐ COPD (496)	☐ Addictions (303-304)
☐ Asthma (493)	☐ Tobacco (305.1)
☐ Heart Failure (428)	
☐ Ischaemic Heart Disease (413-414)	

Part 2 - History

Note: If the required information already exists in another format, the physician may attach a hard copy instead of completing the required fields. The form must still include appropriate signatures.

Problem list (allergies, medical conditions, important medical history, barriers, problems etc.) Add more lines if neccessary.

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Part 2 - History cont'd

Lifestyle Issues and Other Relevant Information

Caffeine	☐ No	☐ Yes	Daily Consumption ______
Smoking	☐ No	☐ Yes	Consumption (day/wk/mo) ______
Alcohol	☐ No	☐ Yes	Consumption (day/wk/mo) ______
Recreational Drugs	☐ No	☐ Yes	Specifics ______
Physical Activity	☐ No	☐ Yes	Specifics ______
Other	Specifics		

Current Medications

Medication	Problem	Dosage
		+ -

Therapies/Interventions

Therapies/ Interventions	No. per year	Scheduled services are to be shown under respective months listed below											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Part 2 - History cont'd

Involvement of Health Care Professionals

Professional	Active or planned	Contact Information (if available)	Additional Information (role, goal linkages, next appt, etc.)
☐ Specialist			
☐ Pharmacist			
☐ Dietician			
☐ Nurse Practitioner			
☐ Physician Assistant			
☐ Psychologist			
☐ Social Worker			
☐ Other			
☐ Other			
☐ Other			

End of Life / Advance Care Planning discussed. If yes, provide details: ☐ Yes ☐ No ☐ N/A

Part 3: Goals

Must be clearly defined and agreed upon between the patient and/or the patient's agent and the physician.

This section is to be completed by the patient in partnership with the physician and/or care team. May include concerns about medical conditions, problems, barriers or next steps, and are followed by actions, solutions, observations, the current status of the goals and expected outcomes, etc.

Goal	Action	Who is Responsible	Expected Outcome	Result
				+ -

Declaration

We (the physician and patient/patient agent) have discussed this care plan and the patient/patient agent has received a written copy of it. A similar document has not been completed with another physician in the past twelve months.

Patient and/or Agent Names _____ Signature _____ Date *(mm/dd/yyyy)* _____

Physician Name _____ Signature _____ Date *(mm/dd/yyyy)* _____

Reset Form Save Print

Frequently Asked Questions

1. How was the fee assigned to HSC 03.04J determined?

   ANSWER The dollar value assigned to the code is $206.70, a figure deemed to be reflective of the time, intensity and complexity involved in collaborating with the patient and developing an appropriate Comprehensive Annual Care Plan.

   The service is classified as a test category code, and can be billed in conjunction with HSCs 03.03A, 03.03N, or 03.04A. HSC 03.04J can currently be billed in addition to 03.04K under very specific circumstances (please see question 6). All other services and procedures needed by the patient in question throughout the year may be billed as usual. Provision has been made for re-evaluation and revision of the fee code within a calendar year, based on the date of service listed in the Comprehensive Annual Care Plan.

2. What is the purpose of the Comprehensive Annual Care Plan HSC?

   ANSWER The Comprehensive Annual Care Plan fee code has been created to recognize that providing quality care to patients with co-morbidities and Comprehensive Annual Care needs requires general practitioners to devote greater than average time and effort.

   The Comprehensive Annual Care Plan is intended to shift the emphasis from episodic care to the more comprehensive, coordinated care required for eligible patients.

   The Comprehensive Annual Care Plan could potentially improve access to multiple health practitioners and provide the remuneration to support the continued development of Chronic Disease Management and Primary Care strategies currently underway in Alberta.

3. What is a Comprehensive Annual Care Plan?

   ANSWER The initial service shall be the development of a Comprehensive Annual Care Plan for a patient, residing in the community with or without assisted living services (excluding long term care facilities), with two

or more of the chronic conditions as set out in the code. This plan should be reviewed and revised at least once per annum and as necessitated by the patient's condition.

"Comprehensive Annual Care Plan" means a single document that meets the following criteria:

a) Must be communicated through direct contact with the patient and/or the patient's agent (agent as defined in the Personal Directives Act (RSA 2007c37s3)).

b) Must include clearly defined goals which are mutually agreed upon between the patient and the physician.

c) Must include a detailed review of the patient chart, current therapies, problem list and past medical history.

d) Must include any relevant information that may affect the patient's health or treatment options, such as demographics (education, income, language, etc.) or lifestyle behaviors (addictions, exercise, sleep habits, etc.).

e) Must incorporate the patient's values and personal health goals in the Comprehensive Annual Care Plan, with respect to his or her complex needs.

f) Must outline expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate.

g) Must identify other health care professionals that would be involved in the care of the patient and their expected roles.

h) Must include confirmation that the Comprehensive Annual Care Plan has been communicated verbally and in writing to the patient.

i) Must be signed by the physician and the patient and/or the patient's agent.

4. Who is eligible to bill the Comprehensive Annual Care Plan HSC 03.04J?

ANSWER Remuneration will only be made in response to a single claim per patient, per year under the HSC 03.04J. The primary care general practitioner *most responsible* for a particular patient's care, is responsible for creating the Comprehensive Annual Care Plan and coordinating the patient's care. This physician is the only person eligible to make a claim under HSC 03.04J. This eligible physician is generally described by the patient as the patient's regular family physician and is recognized by the patient to be the person responsible for creating the Comprehensive Annual Care Plan and coordinating the patient's care.

5. How do I bill the new Comprehensive Annual Care Plan HSC 03.04J?

ANSWER The Comprehensive Annual Care Plan may be claimed in addition to a visit, which is claimed as one following HSCs: 03.03A, 03.03N, or 03.04A. Complex modifiers should be applied only to the visit. Time spent in the preparation of the Comprehensive Annual Care Plan does not count toward the time requirement for a complex modifier.

The Comprehensive Annual Care Plan fee is intended to compensate the physician coordinating the patient's care for the time devoted in preparing a preliminary plan, discussing it with the patient, and then finalizing and documenting the plan. Provision has been made for re-evaluation and revision of the fee code within a calendar year, based on the date of service listed in the Comprehansive Annual Care Plan claim.

6. Can Health Service Codes 03.04J and 03.04K be billed together?

ANSWER According to the Notes attached to 03.04J and 03.04K in the Schedule of Medical Benefits, these services may be billed in addition to each other, but HSC 03.04J is restricted to facility type OFFC (office) or HOME, while 03.04K may only be claimed when performed in a regional facility. Therefore, payment for

03.04J and 03.04K on the same date of service will not be made unless the correct facility codes appear on the claims. Future amendments will be made to the Schedule of Medical Benefits to further clarify the billing rules for 03.04J and 03.04K.

7. May I bill the Comprehensive Annual Care Plan for every patient that I have with two of the qualifying conditions?

   ANSWER Yes, however, the care required by some patients with two qualifying conditions may not be complex enough to require significant time or justify the preparation of a Comprehensive Annual Care Plan. The decision as to whether or not an annual plan should be prepared for a particular patient is left to the professional judgment of the physician coordinating that patient's care.

8. Why is this health service code limited to patients living in their homes or in assisted living?

   ANSWER While there may be exceptions, patients residing in a long term care facility or an acute care facility usually have a resident team of health care providers available to share in the organization and provision of their care. Patients residing in their homes or in assisted living usually do not have such a team, so the organization and supervision of their care is more complex and time-consuming for the patient's general practitioner. Thus, the only two location codes that will be acceptable on a HSC 03.04J claim will be OFFC and HOME.

9. There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of six?

   ANSWER Alberta Health and Wellness' claims data shows that patients living with two or more of the eligible conditions are the most chronically ill in the province and their care represents the highest cost to the health care system. Other conditions may be added to this health service code after utilization has been tracked for the first year it is in use.

10. What do I do if my patient has more than two of the eligible conditions?

ANSWER Review the list of diagnostic codes provided in the information package and chose the two that most appropriately reflect the patient's condition. Remember that, in order for a claim to be paid, it must include one diagnostic code from column A and one diagnostic code from column B, or two diagnostic codes from column A.

11. What should the goals section of the Comprehensive Annual Care Plan consist of?

ANSWER This section should be completed by the patient in partnership with the physician and/or care team. It may include, but is not limited to, concerns about medical conditions, barriers and/or next steps. These should be followed by actions, solutions, observations, the current status of the goals, and expected outcomes.

12. Why do I need to include the patient's values and personal health goals?

ANSWER When patients are asked which health challenges they want to address, and are personally involved in developing action plans to achieve their goals, the patients typically have more positive outcomes. It is important that patients agree to the goals and sign the Comprehensive Annual Care Plan in order to have them take an active role in their own care. For example, asking a patient to simply lose weight may not be a successful strategy. However, working with the patient to mutually agreed that he or she will walk for 10 minutes several times per week may result in more success in improving that patient's health.

13. What exactly has to be in the Comprehensive Annual Care Plan concerning other health care practitioners?

ANSWER It is important that patients are aware of who is part of their health care team and know their names, phone numbers and roles. For example, this section of the Comprehensive Annual Care Plan might say, "Mr. Smith is your dietician and his phone number is 999-999-9999.' Other information, such as the dates of the patient's next scheduled visits, and information that ties each practitioner to a specific goal(s), would also be helpful, but is not required.

14. Why does the Comprehensive Annual Care Plan have to be communicated verbally and in writing?

ANSWER When patients are aware they have a Comprehensive Annual Care Plan, they are more likely to follow it and engage in patient self-management. It is very important to give patients a copy of their Comprehensive Annual Care Plan. This is because they will be able to keep it with them and refer back to their goals and important information while at home. In addition, if patients need to go to an Acute Care Facility or another practitioner, they will be able to bring their care plans with them in order to provide other practitioners with details about their problem lists, medical history, medications, and other relevant information. Remember you do not have to submit the care plan to Alberta Health and Wellness for payment; however, you must maintain a copy of the care plan in the patient's file at all times.

15. Are there resources and/or training available to help me develop Comprehensive Annual Care Plans for my patients?

ANSWER Yes, there are a number of chronic disease management resources available to physicians through your local health region. Towards Optimized Practice (TOP) and the Primary Care Initiatives are two examples. In addition, the Provincial Chronic Disease Management Dissemination "Leading the Way" project is offering free

workshops across Alberta to assist health care professionals in developing care plans for Albertans with chronic conditions.

To access information or register for these workshops, please visit: www.calgaryhealthregion.ca/albertacdm.

To access general information about primary care networks, please visit: http://www.albertapci.ca/Pages/default.aspx

16. Is the Comprehensive Annual Care Plan Health Service Code compatible with The 'Flinders Model' of Chronic Condition Self-Management?

ANSWER The 'Flinders Model' consists of a set of tools and processes that enable clinicians and patients to carry out a structured process that includes an assessment of self-management behaviors, mutual identification of problems, and goal setting leading to the creation of care plans individualized to the patients. It is important to remember that the 'Flinders Model' of care planning may be used as a resource in developing a complex care plan, but physicians may use other models of their choice.

Whatever planning method is used, it is essential that all requirements set out in HSC 03.04J be met in order to submit a claim for payment.