# Comprehensive Annual Care Plan
## Health Services Code 03.04J

## 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

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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.