

Guide to Complex Care billing in Alberta

Alberta Health and Wellness introduced a new Health Service Code to the Schedule of Medical Benefits in April of 2009. This code, **03.04J**, was created in order to compensate physicians in Alberta for developing a Comprehensive Annual Care Plan for a patient living in a community with or without assisted living services (long term care facilities are excluded).

The implementation of this code is meant to encourage physicians to move away from episodic care and towards a comprehensive care plan for patients with complex and/or chronic conditions. It is also aiming to improve patient access to multiple healthcare providers, as well as to increase the communication and effectiveness between these various providers and the patient.

In order to claim 03.04J, a physician needs to meet certain requirements, the most basic of which are:

- being the patient's primary care physician*, and
- intending to provide ongoing comprehensive care to the patient for the conditions that are identified in the comprehensive care plan.

*Physicians claiming 03.04J should make sure to find out if any other complex care plans have been created for the patient within the last year by another care provider. Compensation for this service code will only be paid out once per year per patient. Therefore, only the primary care physician (that is *most responsible* for the patient's care) should be developing the Comprehensive Annual Care Plan in cooperation with the patient and will be eligible to claim this code.

Once a 03.04J claim is assessed and accepted, the physician will receive a value of \$215.52 for the year (as of the April 1st, 2014 Schedule of Medical Benefits update). This fee is meant to cover the time spent preparing the complex care plan, going over it with the patient, and making any adjustments and revisions within a calendar year (starting on the service date of the initial 03.04J claim).

What is a Complex Care Plan?

The complex care plan is a document that includes all relevant information with regard to the patient's health and treatment options for a year. It should include clearly defined goals which are agreed upon by the physician and patient and/or patient's agent. It is prepared in collaboration with the patient so that any relevant values and personal health goals to the complex condition(s) can be addressed.

The purpose of a Complex Care Plan - Patients

It is important to explain to the patient that a complex care plan is being designed for their condition(s). The physician creating the plan should focus on how the condition can be treated in

both the short and long term. This plan should help patients understand their condition better while also providing a helpful management tool to facilitate their achievement of treatment goals.

Benefits for patients include:

- helping patients understand and manage their conditions more effectively.
- helping patients steer through the health care system.
- enhancing the patient's access to a team of qualified healthcare professionals.
- developing a self-management system that patients can use to set and accomplish short and long term goals for their chronic health conditions.

The purpose of a Complex Care Plan - Physicians

The 03.04J service code allows physicians to be compensated by Alberta Health and Wellness accordingly for the time and effort put into creating a complex care plan. It also facilitates the coordination and overall management of patient care and improves the collaboration between a patient's various healthcare providers.

Benefits for physicians include:

- facilitating the compensation process for physicians for the time and effort they spend on managing patients with complex and/or chronic conditions.
- assisting in the overall management and coordination of patient care.
- enhancing collaboration between multiple healthcare providers that contribute to the care of a patient.
- enhancing communication and understanding between patients and their primary care provider.

Conditions for claiming 03.04J

There are a number of conditions that must be met in order to bill for the 03.04J service code for a patient. All of the following conditions need to be fulfilled in order for the claim to be paid by Alberta Health.

1. may only be **claimed by the general practitioner most responsible for primary care** of patient
2. may only be **claimed once a year for a patient** and will include ongoing communication, re-evaluation and revision of the plan within that year.
3. may be **claimed in addition to health service codes 03.03A, 03.03N, 03.04A, or 03.04K** (only if further conditions are met)*.

*03.04K may only be billed in conjunction with 03.04J on the same service date if the appropriate facility codes are on the claims. 03.04J can only be claimed from an OFFFC (office) or HOME facility type, while 03.04K can only be claimed from a regional facility. Payment of both will occur only if the facility codes are correctly claimed on the bill.

4. **may not claim time spent on preparation** of complex care plan in the time requirement for a complex fee modifier.

5. **may only be applied to patients with “complex needs”**, defined as a patient that has chronic diseases and/or other complications. The patient must have a **minimum of two diagnoses from Group A or one diagnosis from both Group A and Group B** in order to be eligible for payment of 03.04J claims. The codes should be displayed in the three diagnostic codes fields available (a third diagnostic code may be included, but isn’t necessary for payment). All subsets of the following codes are also applicable.

Group A	Group 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)	
Chronic Renal Failure (ICD 585)	

6. The “Comprehensive Annual Care Plan” is a single document that must meet the following criteria:
- a) **must be communicated through direct contact with the patient** and/or the patient’s agent (as defined in the Personal Directives Act),
 - b) **must include clearly defined goals which are mutually agreed upon** between the patient and/or patient’s agent and the physician,
 - c) **must include a detailed review of the patient’s chart**, current therapies, problem list and past medical history,
 - d) **must include all relevant information that may affect the patient’s health** or treatment options, including demographics (such as education, income, language) or lifestyle behaviours (such as addictions, exercise, sleep habits, etc.),
 - e) **must incorporate patient’s values and personal health goals** in the care plan, with regard to the complex needs,
 - f) **must outline expected outcomes and results of this plan**, including end-of-life issues when clinically appropriate,
 - g) **must identify other healthcare professionals that may be involved** in the care of the patient and their expected roles,
 - h) **must include confirmation that the care plan has been communicated verbally and in writing** to the patient and/or patient’s agent,
 - i) **must be signed by the physician and the patient or patient’s agent.**

If all of the above conditions are met, a physician is able to claim 03.04J for the patient.

Development, documentation, and administration of a Comprehensive Annual Care Plan

The Comprehensive Annual Care Plan is a single document which outlines a patient's current therapies, medical history, health challenges, and other relevant information about the patient's health, treatment, and other healthcare providers that are active in the patient's care.

The plan needs to include clearly defined goals, discussed and agreed upon by the patient or patient's agent and the physician and is developed in cooperation with the patient. Values, personal health goals, and any other information related to the patient's complex care needs should be taken into account during the development of the plan. The final plan needs to be signed by both parties (the patient/patient's agent and the physician) and copies should be found in the patient's file, as well as given to the patient. The plan should be reviewed and revised at least once a year, as necessary based on the development of the patient's conditions, and should continue to meet the requirements outlined in condition 6.

The goals of the plan need to be discussed between the patient, physician, and/or care team and should include any concerns about the conditions, challenges faced, and steps to take moving forward. The goals should be followed by applicable actions, observations, solutions, current goal status, and any expected outcomes. Patient participation and involvement in the care plan ensures that their concerns and values are acknowledged, while also encouraging them to take an active role in their own care.

The patient should also be aware of which care providers make up the healthcare team and should have names, contact information, and roles of each provider. Providing a copy of the Comprehensive Annual Care Plan to the patient will ensure that they have access to this information from their home and will also be a helpful reminder of the goals laid out in the plan. This will also allow patients to have a record of the specifics of their conditions, medical history, medications, and any other relevant information and will be especially useful in case they require transfer to an Acute Care Facility where care providers may not be aware of these conditions.

It is up to the physician's professional judgement as to which patients with qualifying conditions require the development of a Comprehensive Annual Care Plan. Only patients that reside in their homes or in assisted living facilities are eligible for this care plan. This is due to the fact that they most likely will not have access to the same type of care that those in long term or acute care facilities with a resident team of healthcare providers will have. Therefore 03.04J is only applicable to the OFFC (office) and HOME location codes.

There are a number of resources available for physicians, such as [templates](#) for the plan, as well as a [workbook](#) and [additional information](#). Initiatives such as [Towards Optimized Practice \(TOP\)](#) and [Primary Care Initiatives](#) can also help physicians develop appropriate care plans for their patients.