

# Primary Care Physician Compensation Model (PCPCM)

## Operations Manual – V4.2

January 9, 2026



- 1.0 INTRODUCTION.....5
  - 1.1 Purpose of the PCPCM Operations Manual .....5
  - 1.2 Change Summary .....5
  - 1.3 PCPCM Overview.....5
  - 1.4 Ministerial Order.....6
- 2.0 ELIGIBILITY AND ENROLMENT .....6
  - 2.1 Initial Eligibility .....6
  - 2.2 Enrolment in the PCPCM .....7
  - 2.3 Maintaining Eligibility ..... 10
  - 2.4 Moving Facilities ..... 12
  - 2.5 Withdrawal from the PCPCM ..... 15
- 3.0 PHYSICIAN TOTAL COMPENSATION..... 15
- 4.0 BILLING FOR ENCOUNTERS ..... 16
  - 4.1 Encounter Payments Overview ..... 16
  - 4.2 In-basket Health Service Codes ..... 17
  - 4.3 Out-of-basket Health Service Codes ..... 17
  - 4.4 Complexity Modifiers for Out-of-basket Services..... 18
  - 4.5 Business Costs Program Payments ..... 18
  - 4.5 Payment to Physicians ..... 18
  - 4.6 Virtual Care ..... 19
  - 4.7 Services for Non-paneled Patients ..... 19
  - 4.8 Clinical Services provided by Students, Residents and Trainees ..... 20
  - 4.9 Rural Practice..... 20
- 5.0 BILLING FOR TIME..... 21
  - 5.1 Time-based Payments Overview ..... 21
  - 5.2 Calculating Time..... 23
  - 5.3 Submitting Claims for Time Under the PCPCM ..... 23
  - 5.4 Clinic Practice Management (Administration) Payments ..... 27

5.6 Clinical Teaching Time .....	28
5.7 Patient No-Shows .....	29
6.0 PANEL PAYMENTS .....	29
6.1 Complexity-Adjusted Panel Payments.....	29
6.2 Panel Payment Methodology .....	30
6.3 Payment to Physicians .....	31
6.4 Panel Conflicts .....	33
6.5 Shared Panels .....	35
6.6 Panel Upload Failures and Panel Payments .....	35
7.0 TIME AWAY AND LOCUMS .....	36
7.1 Options for Locums .....	36
8.0 EXCLUDED SERVICES .....	40
8.1 Complexity Modifiers for In-basket Services.....	40
8.2 Out-of-basket Services .....	40
8.3 Services to Non-paneled Patients .....	41
8.4 Workers Compensation Board (WCB).....	41
8.5 Services to Residents of Other Provinces and Territories with a Valid Health Care Coverage Card .....	41
8.6 Services to Residents of Alberta or Other Provinces Without a Valid Health Care Coverage Card .....	42
8.7 Services to Residents of Other Countries.....	42
8.8 Other Uninsured Services.....	42
9.0 NEW PHYSICIANS & RECENT MEDICAL GRADUATES.....	44
10.0 ADMINISTRATION .....	44
10.1 Audit Authority.....	44
10.2 Adequate Records & Documentation.....	44
10.3 Alberta Healthcare Insurance Program Facility Number .....	45
10.4 Written Notices to the Minister.....	45
APPENDIX A: DEFINITIONS .....	46

APPENDIX B - BACKGROUND & PRINCIPLES OF THE PCPCM ..... 51

    PCPCM Guiding Principles..... 51

    The Patient’s Medical Home (PMH)..... 52

APPENDIX C: IN-BASKET VISIT CODES..... 53

APPENDIX D: IN-BASKET PROCEDURE CODES..... 61

APPENDIX E: ANNUAL COMPLEXITY PAYMENTS TABLE ..... 66

    Chart A: Panel Payment Complexity Matrix – Female..... 66

    Chart B: Panel Payment Complexity Matrix – Male ..... 67

## 1.0 INTRODUCTION

### 1.1 Purpose of the PCPCM Operations Manual

The Alberta Medical Association (AMA), in collaboration with Primary & Preventative Health Services (formally known as Alberta Health), developed this document to set out the eligibility criteria, enrolment steps and billing rules for the Primary Care Physician Compensation Model (PCPCM), acting as a comprehensive guide for its application and interpretation.

Changes of significance will be tracked in Section 1.2: Change Summary and may include new information, language revision and clarification of previously published content.

Unless otherwise provided, see [Appendix A: Definitions](#) for key term descriptions.

### 1.2 Change Summary

Updates coinciding with new document versions will be summarized and highlighted in red within the manual to ensure clarity, awareness and traceability of revisions.

- [Section 2.4: Moving Facilities](#)
- [Section 6.2: Updated Sample Statement of Account](#)
- [Section 6.6: Panel Upload Failures and Panel Payments](#)

The previous version of this manual was Version 4.1, published on November 27, 2025.

### 1.3 PCPCM Overview

The Primary Care Physician Compensation Model (PCPCM) is a compensation option for Family Physicians and Rural Generalists who practice in Alberta. Jointly developed by the Alberta Medical Association's (AMA) primary care leaders and Primary & Preventative Health Services (formerly Alberta Health), this alternative payment model supports comprehensive, longitudinal patient care and the financial viability of community clinics.

The PCPCM represents a hybrid between Alberta's default Fee-for-Service funding model (encounter-payments), clinical ARPs (time payment) and capitation (panel and patient complexity-based payment). Existing compensation agreements remain available.

The model is designed to compensate physicians in a way that incentivizes comprehensive, longitudinal patient care to better achieve the pillars of the Patient's Medical Home (PMH). It

acknowledges essential work beyond direct patient care, supports physicians in addressing the unique needs of complex and vulnerable patients and promotes patient attachment to physician practices.

Total compensation under the PCPCM includes:

- patient encounters
- time spent on direct patient care, indirect care and practice management
- complexity-adjusted panel payments

In its development, the concept of a “full-time equivalent” physician was considered, while acknowledging there is significant variation in how physicians work. This concept was used to determine how PCPCM payment mechanisms generate total clinic-based compensation and define eligibility.

Patient care provided by clinical team members is not payable under the model. This includes care provided by nurses, nurse practitioners, allied health professionals and non-clinical staff.

Overhead taken from physician gross payments, as outlined in the physician’s clinic agreement, can be used to fund clinical team members at the discretion of the individual clinic and physician.

## 1.4 Ministerial Order

Like the [Schedule of Medical Benefits \(SOMB\)](#) used in the Fee-for-Service model, the PCPCM is authorized and delivered under a [Ministerial Order \(MO\)](#) - *AMA member login required*.

### **Active MO for the PCPCM: 510/2025**

To maintain compliant participation, all rules and rates defined in the MO must be adhered to from the date effective on the physician’s PCPCM BA. This includes immediate use of the PCPCM BA for eligible services and encounters and adhering to notice requirements – see [Section 10.4: Written Notices to the Minister](#).

## 2.0 ELIGIBILITY AND ENROLMENT

### 2.1 Initial Eligibility

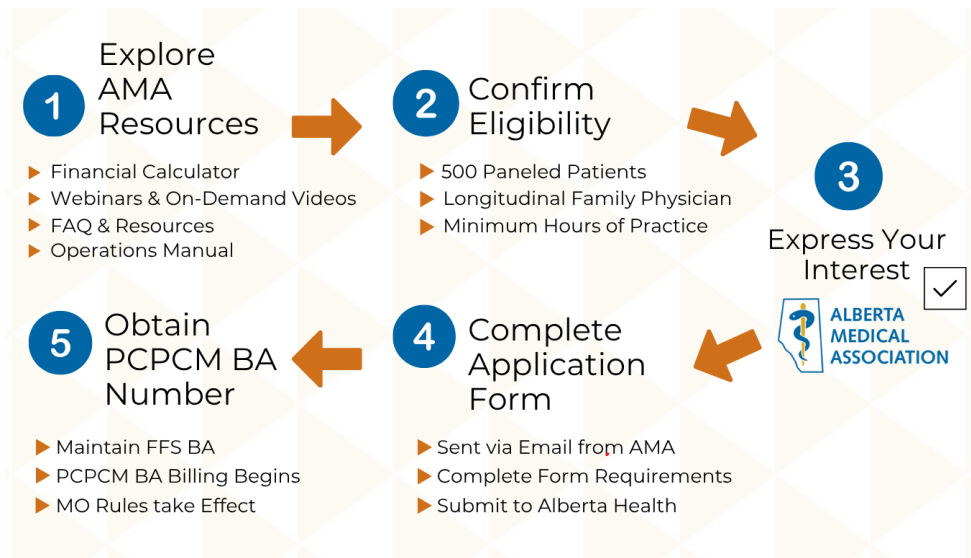
To be eligible for the PCPCM, a physician must meet prerequisites:

- Practice in a community medical clinic that provides in-person, longitudinal family physician services.
  - Family medicine services provided in other facilities, including Long Term Care or Designated Assisted Living, are not eligible for PCPCM billing.
- Provide the majority of their community-based services within relationship-based family medicine to a known panel of patients, aligned with the attributes of the Patient's Medical Home (PMH). See [Appendix B: Background and Principles of the PCPCM](#).
- Meet the practice-time commitment, providing a minimum of 400 hours of direct and indirect care, over 40 or more weeks per fiscal year (April – March).
- Panel patients on a conformed EMR, using the Community Information Integration / Central Patient Attachment Registry (CII/CPAR).
- Maintain a minimum PCPCM panel size of 500 patients. For more information, see AMA's [PCPCM Panel Size Calculation](#) resource.
  - If a physician combines two or more panels, only a single BA is issued and can be attached to a single submitter.
  - If a physician works within two different clinics, all business must be managed under a single PCPCM BA and one submitter.
- Joining the PCPCM as a new-to-practice physician follows a different process than established physicians. The 500 paneled patient minimum is waived for 6 months. See [Section: 9.0 New Physicians & Recent Medical Graduates](#) for more information.
- Commit to develop and/or maintain panel management processes that address panel conflicts and demographic mismatches using [CPAR reports](#).
- Understand when Conflicts may impact panel payments. For more information, see the AMA's [PCPCM Payments & CPAR Conflicts](#) resource.
- Review the PCPCM [MO](#) to understand the compensation structure and model rules.

## 2.2 Enrolment in the PCPCM

Joining the PCPCM requires each eligible physician to express interest and apply. If working at a clinic with multiple physicians, not all physicians are required to join. See [Exhibit 1.2 for a visual overview of the PCPCM enrolment process](#).

Physicians are not required to practice exclusively under the PCPCM and will continue to hold a Business Arrangement for Fee-for-Service (FFS BA).



*Exhibit 1.2: PCPCM Enrolment Process*

**TIP:** Physicians interested in the PCPCM but know they will be changing clinics within three months of their application are encouraged to wait and apply once their panel is established at the new clinic.

## How to Verify Eligibility, Express Interest and Receive a PCPCM BA

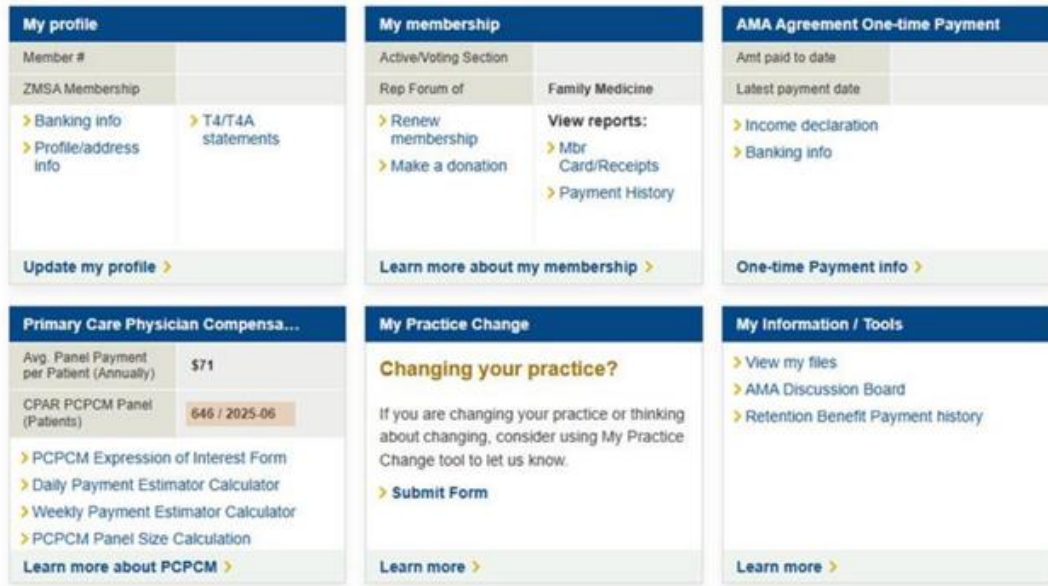
### Step 1 – Eligibility Verification

Log into the [AMA Member Dashboard](#), *Member login required*.

On the Dashboard, review *CPAR PCPCM Panel (Patients)* and *Avg. Panel Payment per Patient (Annually)*. See [Exhibit 2.1](#) for a visual of the [AMA Member Dashboard](#). To be eligible, the physician's PCPCM panel size must be 500 patients or greater, as indicated by the *CPAR PCPCM Panel (Patients)* data\*.

**Eligibility verification for new-to-practice physicians follows a different process. See [Section: 9.0 New Physicians & Recent Medical Graduates](#) for more information.**

Use *Avg. Panel Payment* for financial modeling with AMA's [Financial Calculator](#), *Member login required*. Members of AMA-ACCTT's [Clinic Managers Network](#) can also access the Calculator.



*Exhibit 2.1: AMA Member Dashboard visual*

\*As of July 2025, physicians who are already live on the PCPCM model will not see updated CPAR PCPCM Panel (Patients) data in the AMA Member Dashboard. This data, provided by PPHS, will be updated monthly for non-PCPCM physicians only.

For information on where to find up-to-date panel data for physicians on the model, see [Section 2.3: Maintaining Eligibility](#).

**Step 2 – Expression of Interest**

Select the checkbox to complete the ‘Expression of Interest’ form. *See Exhibit 3.1 for a visual of the PCPCM Expression of Interest.* After submitting, physicians will receive a confirmation email from the AMA. Only physicians with 500 patients or more will be able to access this checkbox.

**TIP:** If a physician is building their panel to meet or maintain eligibility, there will be a month-long lag in the AMA Member Dashboard, in line with the monthly panel upload schedule to CPAR.

Physician Comprehensive Care Model (PCCM) Expression of Interest

I am interested in enrolling in the Physician Comprehensive Care Model (PCCM) and have confirmed I meet the requirements of a 500 patient panel and will provide 400 hours of direct and indirect care to my patients over at least 40 weeks each year.

Submit

*Exhibit 3.1: PCPCM Expression of Interest visual*

### Step 3 – PCPCM Application & Ministerial Order

Physicians will receive a 'Primary Care Physician Compensation Model (PCPCM) Clinical Alternative Relationship Plan (ARP)' Application form. The form is unique to the recipient of the email and cannot be used by other physicians. Physicians will also receive a copy of the Alberta Health Ministerial Order (MO) which can be viewed on the [AMA website](#), *Member login required*.

Download Application form, complete all fields, save and send to the Ministry at [health.PCPCMform@gov.ab.ca](mailto:health.PCPCMform@gov.ab.ca). Applications are processed on an ongoing basis, with rolling monthly deadlines and start dates. For more details, see the Alberta Government's [March 24 Bulletin](#).

**TIP:** For detailed instructions on completing or resubmitting an application, see AMA's [How To Guide](#). Instructions can also be found on the form under the Instructions tab.

### Step 4 – Model Entry & PCPCM Billing

Following successful processing of the Application Form, PPHS will issue the physician's new PCPCM Business Arrangement Number (PCPCM BA) by regular mail.

Upon model entry, physicians must adhere to the rules and rates defined in the MO. This includes immediate use of the PCPCM BA for eligible services and encounters. See [Section 1.4: Ministerial Order](#) for more details.

## 2.3 Maintaining Eligibility

After obtaining a PCPCM BA, commitments must be made to maintain eligibility, relative to the full-time equivalence and panel management.

### 1. Panel Size

If a physician's PCPCM panel drops below the required minimum, they will have 12 weeks to bring it back up to 500. Physicians or their teams should monitor their panel size monthly, as well as CPAR reports on panel conflicts and demographic mismatches. For more information, see AMA's resource on CPAR reports and [Section 6.4 Panel Conflicts](#).

If a PCPCM panel size drops below 500 patients for more than 12 weeks, the physician will receive notice from PPHS and their PCPCM BA will be terminated. For more information, see [Section 2.4 Withdrawal from the PCPCM](#).

Starting July 2025, physicians on the PCPCM model will not see up-to-date *CPAR PCPCM Panel (Patients)* data in the AMA Member Dashboard. To ensure panels don't drop below the minimum number of patients required to stay eligible, physicians and teams should regularly review their Panel Submission Metrics Report in CPAR and their PCPCM Panel Payment Summary.

For a visual, see Exhibit 8: Sample PCPCM Panel Payment Summary (PC001 Report) in [Section 6.3: Payment to Physicians](#).

**TIP:** If moving clinics, PCPCM physicians should ensure the new clinic is on CII/CPAR prior to moving. This ensures that interruptions to CPAR uploads from your EMR are minimized. See [Section 2.4](#) for more information.

## 2. Patient Care, Off-loading and In-Clinic Services

A physician must continue to provide timely, accessible, comprehensive and relationship-based care to paneled patients and to offer care primarily in-person.

A physician is not to engage in “off-loading” paneled patients to Fee-for-Service (FFS) physicians. Off-loading is considered shifting care for paneled patients to FFS physicians when the primary PCPCM physician could have provided that care.

The key consideration is what is reasonable in the given context. For example, having a Locum available for same-day, more urgent visits seems reasonable. However, if a Locum is routinely seeing the same overflow patients, it may be important to assess whether panel size and demand are impacting access.

Where the request to shift care is patient-initiated, this is not considered off-loading.

*Example: A patient requests to have a female physician perform an IUD insertion.*

A physician must not be inactive for 12 or more consecutive weeks – this does not include temporary absences or a decrease in days worked related to illness, vacation, parental leave, caregiving, military deployment or other reasons. For more information, see [Section 7.1: Time Away](#).

### 3. PCPCM BA Number

A PCPCM BA is maintained year over year, as long as the physician upholds eligibility and does not withdraw from the model.

**TIP:** Physicians will only receive one PCPCM BA. Physicians who work in more than one clinic must submit claims using a single submitter or bill under PCPCM at only one of their clinics.

### 4. Health Quality Council of Alberta Reports

If a physician is not already receiving Health Quality Alberta (HQA) [Primary Healthcare Panel Reports](#), they should request a copy of their confirmed panel report through the HQA website. Under Section 2.3 (i) of the [\(MO\)](#), HQA panel reports must be provided to the Minister upon request.

This is not an automated data transfer and does not expand the Minister's existing rights. Access to this data supports the ongoing evaluation of the PCPCM model, ensuring it continues to meet the needs of physicians and patients. PPHS has access to this information through the data already provided to HQA but may require more efficient access through physicians.

## 2.4 Moving Facilities

### First 90 Days After Go-Live

The PCPCM application form asks physicians to attest that they will not be changing or moving from identified facility(ies) for the first three months on the model. If the physician knows they will be moving clinics during this period, they must wait until they are established at the new clinic before applying for a PCPCM BA. Additionally, physicians should be aware of related CII/CPAR processes required before clinic moves.

### Notification to the Minister

The minister must be notified at least 30 days prior to beginning service provision at the new facility. The effective date at the new facility must be the first day of the month. For example, if a physician provides notice to the Minister on June 15<sup>th</sup>, the earliest effective date would be August 1<sup>st</sup>.

**Considerations: Planning to Move Facilities**

- Must be live on CPAR at the new facility
  - EMR at the new facility must be CPAR-conformed
  - A new panel must be created and populated (CPAR Panel numbers cannot be transferred)
- If a transfer of data needs to occur from the previous facility to the new facility:
  - Data migration should be planned and scheduled with EMR vendors prior to starting practice at the new facility
  - This could extend the transition time which risks interruptions to CPAR panel uploads
  - Migrated data could cause inaccurate paneling in the new EMR

**Process**

Changes made to a PCPCM BA are effective on the first calendar day of the month.

1. Complete a “Physician Move to New Facility Request” ([PCN14839](#)) form.
  - a. Change banking information as needed
  - b. Change claims submitter
  - c. Change mailing address, as needed
  - d. Add the new CPAR panel ID# but DO NOT remove the old CPAR panel ID#
  - e. Submit notice to [health.pcpcmform@gov.ab.ca](mailto:health.pcpcmform@gov.ab.ca) at least 30 calendar days prior to moving clinics.
2. Set up your CPAR panel at the new facility and populate it with patients. It is okay to have the new panel set-up while still practicing at the previous facility.
  - a. CPAR panels are linked to PCPCM on the first of a given month
    - i. If patients are added to CPAR mid-month, they will not be connected to PCPCM until the first of the month following upload to CPAR.
3. Manage overlap between the previous and new panels.
  - a. If patients from the previous facility are also paneled in the new facility, a data transfer may be beneficial.
  - b. Work with EMR vendors to transfer patient records prior to starting practice at the new facility and ensure that CPAR required data is included.
    - i. Date of Last Visit
    - ii. Date of Last Validation
    - iii. Patient Status (if applicable)

4. Reconcile any claims at the previous facility prior to submitting PCPCM claims at the new facility.
5. Terminate panel at the previous facility. Steps to terminate vary for different scenarios:
  - a. New CPAR panel is live before starting at the new facility
    - i. Have the previous facility submit a CPAR Panel Request form to terminate the previous CPAR panel with the termination effective date being the last day the physician worked there.
  - b. New CPAR panel NOT setup yet OR the data migration of patient records not complete AND most of your patients are following physician from the previous facility to the new facility.
    - i. Ask the previous facility to maintain your CPAR panel until you have the new CPAR panel set-up. Once the CPAR panel is set-up and the data migration from the previous to new EMR is complete, have the clinic terminate the CPAR panel effective immediately (CPAR Panel Request form).
  - c. New CPAR panel NOT setup yet OR the data migration of patient records not complete yet AND most of your patients are NOT following physician from the previous facility to the new facility.
    - i. Ensure the new facility is working with eHealth to set up the physician's new CPAR panel.
    - ii. Terminate the old CPAR panel effective the last day the physician practices at the previous facility using the CPAR Panel Request form. This drops your panel size to zero and you have 90 calendar days to build your new live CPAR panel to 500+ patients.
6. Begin making claims with your new PCPCM BA on the first day it is active at the new facility.
7. Panel Administrator should check CPAR portal monthly to confirm successful uploads and panel sizes until they exceed the 500-patient minimum.

### **Limitations**

Physicians can change facilities once every 12-month period beginning the day they went live with their PCPCM BA.

## 2.5 Withdrawal from the PCPCM

Formal withdrawal is required when a physician:

- No longer wishes to participate in the PCPCM
- Leaves the practice in Alberta
- Other circumstances where there is no longer an intention to bill services under the PCPCM

Under extenuating circumstances, such as a personal health issue or an unexpected family emergency, the physician may submit a request to re-enter the program earlier than 12 months. **These requests will be reviewed by a steering committee, struck by PPHS on a case-by-case basis.**

### Notice of Departure Form

The Notice of Departure Form ([PCN 14851](#)) can be found on the [Health Professional Business Forms webpage](#). Completed forms can be submitted via email to: [health.pcpcmform@gov.ab.ca](mailto:health.pcpcmform@gov.ab.ca).

Physicians must list their PCPCM BA termination date, allowing at least 30 days' notice to the Minister. Until that date, the physician will continue to submit claims using their PCPCM BA.

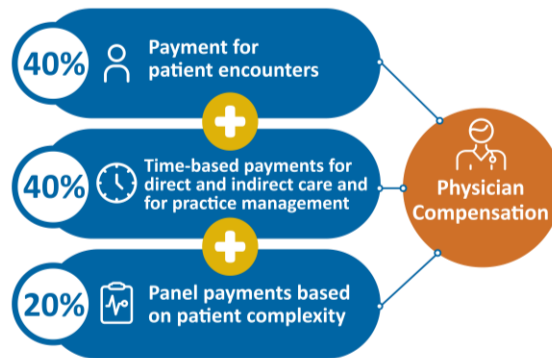
Primary and Preventative Health Services will issue a final panel payment in accordance with the last panel submission, not the final month a PCPCM BA is active. Physicians are encouraged to provide as much notice as possible. A departure date earlier in the month would mean fewer days working under PCPCM without a panel payment.

***Withdrawal Timeline Example:*** *If a Notice of Departure is received by the Minister's Office on April 14, the physician's departure date and last date of activity in the model will be May 14.*

- *May 1: Panel is decoupled from PCPCM*
- *May 14: Last day to submit PCPCM BA claims*
- *May 14 – end of day: PCPCM BA is terminated*
- *May 15: FFS BA must be used for claims*
- *May 30: Final PCPCM panel payment for April is processed*

## 3.0 PHYSICIAN TOTAL COMPENSATION

Total compensation for PCPCM physicians is made up of three components. *See Exhibit 4.1 for a visual of the PCPCM compensation components.*



*Exhibit 4.1: PCPCM Compensation Components Visual*

### 1. Payment for Encounters

- Billed at 68.5% of fee for in-basket service value using most commonly used codes for family medicine visits and procedures

### 2. Payment for Time

- \$105 per hour for direct and indirect care
- After-hours premium of +\$87.72 (\$105 + \$87.72 = \$192.72) for direct patient care
- Office administration and practice management activities automatically applied to 10% of time claims at a rate of \$105 per hour

### 3. Panel Payment

- Adjusted for patient age, sex and complexity using Canadian Institute for Health Information Population Grouping Methodology (CIHI POP Grouper)
- Uses the PCPCM panel derived from CPAR. The PCPCM panel is all patients uploaded to CPAR with an Alberta Health Care Insurance Plan Number.

See [Section 4.0 Billing for Encounters](#) and [Section 5.0 Billing for Time](#).

## 4.0 BILLING FOR ENCOUNTERS

### 4.1 Encounter Payments Overview

The encounter payment component of the PCPCM recognizes services provided to patients. Operating under the model, physicians are expected to provide comprehensive, longitudinal care to a defined panel of patients.

Only the GP skill is eligible under this payment model. If a skill other than GP is used for a claim, it will be refused with an Explanatory Code of 99A appearing on the Statement of Assessment.

## 4.2 In-basket Health Service Codes

The PCPCM uses existing fee-for-service Health Service Codes. A single basket of Health Service Codes for visits and procedures is defined and represents approximately 94% of all family physician service claims. This list of Health Service Codes is referred to as “in-basket” (See [Appendix C: In-Basket Visit Codes](#)).

The majority of services provided by physicians practicing longitudinal family medicine will be represented and compensated for by the in-basket billing codes. In-basket visit codes and procedure codes are paid at a reduced rate of 68.5% of the FFS value. Discounted codes will show the Explanatory Code of 99C on Statements of Assessment.

The reduced rate for procedure codes will only be applied to the service fee portion and most Fee Modifiers (e.g., ANE, NBPG, and BMI modifiers). The discount does not apply to the tray fees paid according to the rules of the [Schedule of Medical Benefits \(SOMB\)](#).

Tray fee modifiers MAJT (major tray) and MINT (minor tray) are not discounted. NBTR (number of trays) follow the same rules as Fee-for-Service. For more information, see the Alberta Government’s [Schedule of Medical Benefits](#).

When billing for multiple procedures, rules for FFS apply.

### **Example Billing: 03.03A visit code (assessment)**

*GP Rate = \$40.23*

*PCPCM Reduced Rate =  $\$39.49 \times 0.685 = \$27.56$*

### **Example: 98.12A visit code (excisional biopsy, skin)**

*GP Rate = \$43.53*

*PCPCM Reduced Rate =  $\$43.53 \times 0.685 = \$29.82$*

*Tray fee @ 100% = \$38.88*

For time-based encounter codes, such as 08.19G, this is claimed as usual, and PCPCM time-based Health Service Codes (described below) can also be claimed.

## 4.3 Out-of-basket Health Service Codes

Any Health Service Codes billable by a family physician or rural generalist, not defined in the list of in-basket codes, are considered “out-of-basket”.

***Examples of out-of-basket codes:***

*75.64 (Vasectomy)*

*03.7BA (Medical Assistance in Dying – Determination Phase)*

*03.03NA (Home visit to patients residing in Assisted Living, Designated Assisted Living, group homes, seniors' lodges or personal care home, first patient)*

*03.03NB (subsequent patients).*

These Health Service Codes, aligned to services performed in the physician's clinic, will be billed using the physician's PCPCM BA and paid at 100% FFS value.

When operating outside of the PCPCM, in facilities such as hospitals, long term care and designated assisted living, Health Service Codes must be billed using the physician's FFS BA, paid at 100% FFS value.

## 4.4 Complexity Modifiers for Out-of-basket Services

Complexity modifiers, including time modifiers (e.g. CMGP01 or CMXC30) can be claimed for applicable out-of-basket codes.

Paid at 100% FFS value, time spent providing an out-of-basket service, using PCPCM time-based codes, cannot be claimed.

## 4.5 Business Costs Program Payments

Business Costs Program (BCP) payments are not eligible for billing or payment under a PCPCM BA.

## 4.5 Payment to Physicians

Encounter and time-based codes claimed using a PCPCM BA follow the same payment distribution schedule as claims submitted under the Fee-for-Service model. Physicians will receive a Statement of Assessment from PPHS containing new explanatory codes for the PCPCM. On the Statement, Explanatory Code 99C will appear on all discounted claims (in-basket codes). *See Exhibit 5.1 for a sample Statement of Assessment.*

GP must be submitted under the claim skill field - other skills used under a PCPCM BA will be rejected.

Dr. Yabolbink Sihush  
 UAT Test Environment  
 508 6 Ave  
 Beaverlodge AB T0M 0C0

STATEMENT OF ASSESSMENT

Reference Nbrs  
 59705210 4.97E+08

Business Arrangement 3722-810  
 Expected Payment Date 2025/02/20

Sequence Nbr  
 2

Patient Name	Chart Number	PHN	Claim Number	Service Start Date	Service Code	Claimed Amount	Assessed Amount	Mod Code	Mod Code	Result Code	Exp Code	Exp Code	Registration Number	RC
Sihush, Yabolbink		2892-51008												
Winklehairoute, Spiked		12942-6000	QST 23YC01558943	2025/02/01	08.19G	0.00	244.42			APLY			99C	
Insect, Spider Man		12993-2100	QST 23YC01558941	2025/02/01	03.03A	0.00	27.56			APLY			99C	
Candle, Birthday		13042-3100	QST 23YC01558220	2025/02/01	10.16B	0.00	22.40		NBTR01	APLY			99C	
Zietaraki, Zama		13527-9100	QST 23YC01558221	2025/02/01	98.81A	0.00	105.66			APLY			99C	
Wasper, Opat		13223-5000	QST 23YC01558238	2025/02/01	03.26	0.00	94.05	ANEST		APLY				
Time-Based, PCPCM		10814-7612	QST 23YC01558254	2025/02/01	PC001	0.00	625.00			APLY				
Time-Based, PCPCM		10814-7612	QST 23YC01558321	2025/02/01	PC002	0.00	210.00			APLY				
Time-Based, PCPCM		10814-7612	QST 23YC01558254	2025/02/01	PC004	0.00	1,927.20			APLY				
Total Amount to be Paid							3256.29							
Total Amount (RVRSL)							0.00							
Summary Total														
Provider Name							Assessed Amount							
Sihush, Yabolbink							3256.29							
Total Amount to be Paid							3256.29							

*Exhibit 5.1: Sample Statement of Assessment*

Panel payments and practice management payments will be observed in the Statement of Account Changes. A sample statement can be found in Section 5.0 [Billing for Time](#) and [Section 6.0 Panel Payment](#).

**TIP: Rules** regarding claims submission, processing and timelines remain the same as Fee-for-Service. For more information, see Alberta Government’s [Physician Resource Guide](#).

### 4.6 Virtual Care

The majority of virtual care codes are considered in-basket (see [Appendix C: In-basket Visit Codes](#)). As with Fee-for-Service, virtual care must be provided in accordance with College of Physicians and Surgeons of Alberta (CPSA) standards. As defined in the [Schedule of Medical Benefits \(SOMB\)](#), start and stop times are required for virtual care encounters.

For more information, see CPSA’s [Virtual Care Standard of Practice](#).

### 4.7 Services for Non-paneled Patients

Under the PCPCM, physicians must commit the majority of their community-based clinic time to providing services to their paneled patients. Where comprehensive, longitudinal care is provided to a defined panel of patients, the PCPCM BA should be used. However, physicians will retain their FFS BA and continue to use it when services are not provided in their designated community-based clinic location. This ensures physicians who want to join the PCPCM can continue to offer services in AHS or other facilities (e.g., Long Term Care and Designated Assisted Living) and offer consult clinics and walk-in clinics.

### **Services for Non-paneled Patients in Longitudinal Family Practice**

Where occasional non-paneled patients are seen throughout the day, the physician's PCPCM BA can be used, and time can be claimed (see Section [5.0 Billing for Time](#)). If a physician is cross-covering paneled patients for a colleague in the clinic, the physician providing services can bill their PCPCM BA.

### **Services for Non-paneled Patients in Specialty Clinics**

Where non-paneled patients are seen as part of a specialty clinic, the physician will use their FFS BA and time cannot be claimed (see [Section 5.0: Billing for Time](#)).

Specialty clinics include, but are not limited to:

- Defined walk-in portion of the day
  - Specifically, if this defined period includes non-paneled patients and patients from outside of the clinic (meaning these patients are not paneled to another physician within the clinic)
- Consult clinic (e.g., vasectomy clinic, dermatology clinic)

## **4.8 Clinical Services provided by Students, Residents and Trainees**

Clinical teaching is a vital component of patient care, with physicians actively engaged in medical and interprofessional education, acting as Supervising Physician for Clinical Learners.

For payment purposes, Clinical Learners include medical students, residents, Practice Ready Assessment (PRA-AB) physicians, nurses and nursing students, nurse practitioners and nurse practitioner students, as well as midwives and midwifery students. Compensation for clinical teaching using Health Service Codes payable to the Supervising Physician for patient interactions provided by Clinical Learners can occur when:

- Patient care is provided in-person, the Supervising Physician must also be present
- Patient care is provided virtually, the Supervising Physician must be available in person, by phone or video conference in a timely matter

Supervising Physician must review the patient interaction and sign off on the medical record, consistent with Fee-for-Service. For more information, see [Med Bulletin 97](#).

## **4.9 Rural Practice**

Rural generalists often provide both community-based family medicine services to a panel of patients and coverage and services in hospitals and facilities (e.g., Long Term Care and Designated Assisted Living).

To be eligible for PCPCM, all physicians, including rural generalists, must provide community-based services to a minimum of 500 paneled patients. Physicians also retain their ability to claim services for non-paneled patients through an existing FFS BA. This ensures physicians who want to join the PCPCM can continue to offer services in AHS facilities, walk-in clinics and other facilities, such as long-term care and designated assisted living.

The encounter component of the PCPCM is eligible for Rural Remote Northern Program (RRNP) payments. For the purposes of calculating the RRNP payment, encounter rates are valued at 100% of their FFS value. RRNP is currently under review by PPHS. *More information is coming soon.*

## 5.0 BILLING FOR TIME

### 5.1 Time-based Payments Overview

The time-based component of the PCPCM recognizes the value of patient care in and out of the examination room and acknowledges that patients have unique needs. Time-based claims are billed in addition to Health Service Code billings. Physicians are also compensated for clinic practice management (administration) automatically.

When developing the rates for PCPCM's time-based (direct, indirect and practice management) compensation, payments received by Fee-for-Service model physicians through the Business Costs Program (BCP) and use of Complexity Modifiers were considered. See [Section 4.4: Complexity Modifiers for Out-of-basket Services](#) and [Section 8.1: Complexity Modifiers for In-basket Services](#) for more information.

#### **Rate for Direct & Indirect Care**

\$26.25 per 15 minutes or \$105 per hour

#### **After-hours Premium Rate for Direct Patient Care**

\$21.93 per 15-minutes or \$87.72 per hour in addition to the hourly rate for direct care

\$105 per hour + \$87.72 per hour totaling to \$192.72 per hour

5:00 p.m. to 11:00 p.m. on Weekdays

7:00 a.m. to 11:00 p.m. on Weekends & Statutory Holidays

Over the course of a fiscal year (April-March), a maximum of 20% of total claimed time can be during premium rate hours. Physicians are expected to monitor hours claimed with the premium rate throughout the fiscal year to ensure compliance.

**Clinic Practice Management (Administration) Rate**

In acknowledgement of the time required to operate and manage their clinics, physicians will be remunerated for an additional 10% of their total hours billed for direct, indirect and after hours care at a rate of \$105 per hour. This is paid automatically on a weekly basis.

*See Exhibit 6.2 for a sample Statement of Account.* In yellow, PCPCM Administration denotes payment for clinic practice management.

1	Dr. October Snowy	Statement Date		
1	10021 Jasper Ave NW	Year Month Day		
1	Edmonton AB T5J 1S6	2025 06 10		
1				
1				
1		Method of Payment: EFT		
1		SOA Reference Nbr: 880236100		
Payee Dr. October Snowy				
Expected Payment Date: 2025/06/11				
		Total Amount:	1,040.10	
-----				
	Description	Reference Date	Business Arrangement	Amount
	Statement of Assessment	327722210	2025/06/10 6943810	34.87
	Provider ID 4752-41008 Dr. October Snowy			34.87
	PCPCM Administration - 6943810	332499600	2025/06/11	5.26
	PCPCM PNL PMT Apr 2025 6943810	382496000	2025/06/11	999.97
-----				
	Description	Amount		
	Statement of Assessment	34.87		
	PCPCM Administration - 6943810	5.26		
	PCPCM PNL PMT Apr 2025 6943810	999.97		
	Total Amount:	1,040.10		

*Exhibit 6.2: Sample Statement of Account*

*Updated sample statement provided by PPHS with highlighted area indicating the BA number (PCPCM PNL PMT Apr 2025 6943820) for PCPCM panel payment for the month of April.*

**DIRECT PATIENT CARE UNDER THE PCPCM**

Direct patient care includes services such as, but not limited to:

- Patient history
- Physical examination
- Appropriate advice to the patient, their family, guardian and/or chaperone at the time of the visit
- Physician time spent on family conferences for patients paneled to the physician and not in an AHS facility at the time of the service
- Discussion and facilitation of relevant investigations and treatment plan
- Discussion with a referring or consulting physician
- Virtual care services

**INDIRECT CARE UNDER THE PCPCM**

Indirect care includes services such as, but not limited to:

- Reviewing labs and other investigation results
- Reviewing consult letters
- Responding to faxes, emails or other electronic communications
- Physician time spent on care team coordination
- Chart review, charting and/or writing referral letters on a separate date of service from the visit
- Completion of required forms
- Medical certificates for insured services

Indirect care can be billed on days when no direct patient care is provided.

## 5.2 Calculating Time

Payments for time must be claimed on a cumulative basis per day. Cumulative time is calculated by adding the total time spent delivering patient care as identified in the description of the Health Service Code, over the course of the day and dividing the total time by the time units specified in the Health Service Code to determine the appropriate number of calls.

Time payments are billed in 15-minute increments. These Health Service Codes can be submitted for blocks of time and must reference the non-patient specific Unique Lifetime Identifier (ULI) – not specific to a patient.

***Example: Calculating Time during Regular Hours in Clinic***

*Physician works an 8-hour clinic day with 30 minutes for lunch. They will submit 30 calls for direct patient care.*

***Example: Calculating Time during Regular Hours in Clinic and At Home***

*Physician works an 8-hour clinic day with 30 minutes for lunch. In the evening, they spent 45 minutes charting. They will submit 30 calls for direct patient care and 3 calls for indirect care.*

## 5.3 Submitting Claims for Time Under the PCPCM

Claims for time are submitted for each day of service. As with Fee-for-Service, time-based claims to the Alberta Health Care Insurance Plan are not payable if received by Primary and Preventative Health Services more than 90 days after the service was provided. Claim

assessments and expected payment dates follow the same process as Fee-for-Service and will appear on the Physician Statement of Assessment.

Physicians must use their PCPCM BA for these claims. If time-based health codes are submitted with a FFS BA, they will be refused and be reflected on the Statement of Assessment under Explanatory Code 99B. Physicians can re-submit these rejected claims using their PCPCM BA, as long as those resubmissions are made within 90 days of when refused claims appear on the Statement of Assessment.

Physicians can bill for time when the majority of patients seen during the day are part of their defined panel of patients using in-basket billing codes. If a physician sees their paneled patients during the day and Hosts a walk-in clinic for non-paneled patients in the evening, they cannot bill the PCPCM time-based payment codes for time spent providing walk-in services.

Time-based claims using a PCPCM BA for out-of-basket services (which are paid at 100% FFS value) and uninsured services is not allowed, whether those patients are paneled or not. For more information, see AMA's [Guide to Uninsured Services](#) (AMA member login required).

**Example: 75.64 Vasectomy**

- *paid at 100% FFS value*
- *time spent on this procedure cannot be claimed*

**Example: Completing a private medical insurance form**

- *Patient is invoiced for payment*
- *PCPCM time-based codes cannot be claimed.*

There is no ratio for billing direct vs indirect care hours though time claimed for direct care is expected to exceed that claimed for indirect care. Claims for time that exceed typical hours by peer family physicians are more likely to result in a review and/or audit.

No more than 20% of the total hours claimed should be billed using the after-hours premium. This is calculated relative to the fiscal year (April-March). This allows flexibility in how after-hours clinics are scheduled throughout the month.

After-hours may exceed the 20% maximum and are not expected to shift their practice patterns. For example, if some clinic days are scheduled from 12pm to 8pm, slightly exceeding 20% of total hours in the fiscal year is allowed.

A physician cannot claim time spent on excluded services. Please see [Section 8.0: Excluded Services](#) for more information.

All time codes are claimed using a non-patient specific unique lifetime identifier (**ULI**) of **10814-7612**. Physicians must use the correct ULI for these claims. If the wrong ULI is used, they will be refused and be reflected on the Statement of Assessment under Explanatory Code 99D.

**TIP:** To submit these Health Service Codes, some EMRs require a diagnostic code. Use **Code 780** (ICD-9 diagnostic code for general symptoms).

There are four Health Service Codes for claiming time under the PCPCM. Details related to time claims must be documented and made available upon request to PPHS. These codes are only applicable for time spent under the physician’s PCPCM BA.

Code	Definition and Usage	Max Calls (Daily)
<b>PC001</b> <b>Business Hours Direct Patient Care</b>  \$26.25 per 15 minutes	<ul style="list-style-type: none"> <li>Time spent delivering direct clinical services, under PCPCM, between 0700-1700 hours, on weekdays, per 15 minutes.</li> <li>Charting of encounters between patients, at time of service, is billed as direct time.</li> </ul>	40
<b>PC002</b> <b>Indirect Patient Care</b>  \$26.25 per 15 minutes	<ul style="list-style-type: none"> <li>Time spent delivering indirect care under the PCPCM (see examples in Section <a href="#">5.1</a>).</li> <li>The patient does not have to be present or have an encounter with the physician on the same day as indirect care.</li> <li>Claims for indirect time do not have to be for services which are in the <a href="#">SOMB</a>.</li> <li>Details regarding the time claimed must be documented.</li> </ul>	44
<b>PC003</b> <b>After Hours Weekday Direct Patient Care</b>  \$48.18 per 15 minutes	<ul style="list-style-type: none"> <li>Time spent delivering clinical services, under PCPCM, between 1700-2300 hours on week days, per 15 minutes.</li> <li>Charting of encounters at time of service is billed as direct time. If the service is after hours, then the charting time is eligible for the afterhours premium.</li> </ul>	24

	<ul style="list-style-type: none"> <li>Virtual care during this time should be complimentary to in-person care and so clinics who only deliver virtual care may not claim the premium rate.</li> </ul>	
<p><b>PC004</b>  <b>After Hours Weekend/ Statutory Holiday Direct Patient Care</b></p> <p>\$48.18 per 15 minutes</p>	<ul style="list-style-type: none"> <li>Time spent delivering direct clinical services, under PCPCM, between 0700-2300 hours on weekends and statutory holidays per 15 minutes.</li> <li>Charting of encounters at the time of service is billed as direct time.</li> <li>Calls to patients made from home can be claimed using the after-hours premium.</li> <li>Virtual care during this time should be complimentary to in-person care and so clinics who only deliver virtual care may not claim the premium rate.</li> </ul>	<p>64</p>

If charting is completed on the same day of the service, then the time-based health service code used depends on:

- time of patient visit
- time between visit and charting

*Example: If a physician sees patients from 8am to 4pm and charts are completed for each patient during the visit or between visits, this is all considered direct care time (PC001). If a physician were to batch their chart in the evening, this is considered indirect care time (PC002). Completing charts in the evening is not eligible time for the after-hours premium. However, if a physician sees patients after hours, and completes charts for those patients on the same day after hours, then that time charting is eligible for the after-hours time premium (PC003 or PC004). If charting on a different day of service, it is always considered indirect care time.*

For information on how to use the ULI code and track time within the EMR, see AMA’s resource, [Billing for Time by EMR](#).

Holidays are defined under General Rules 1.2 and 1.3 of the SOMB and include:

- New Year’s Day
- Family Day
- Good Friday

- Victoria Day
- Canada Day
- Alberta Heritage Day
- Labour Day
- Thanksgiving Day
- Remembrance Day
- Christmas Day
- Boxing Day

Instances where the holiday falls on a weekend the Minister shall designate another day as the “holiday.”

## 5.4 Clinic Practice Management (Administration) Payments

Non-patient office administration and practice management are essential components of operating a longitudinal family practice. The inclusion of Clinic Practice Management payments in the PCPCM allows physicians to work on optimization and practice improvement.

These payments are not associated with a Health Service Code and will be calculated automatically by Primary and Preventative Health Services, taking 10% of the total number of hours a physician has billed for direct and indirect care and multiplying them by a rate of \$105.00 per hour.

*See Exhibit 6.2 for a sample Statement of Account. Payments are displayed on the Statement of Account as “PCPCM Administration.”*

**Example:** *Physician works 35 hours in a week. They will need to submit PC001, PC002, PC003 and PC004 time-based codes for the 35 hours, and will automatically receive \$367.50 for clinic practice management.*

*(35 hours x 0.1) x \$105 per hour = \$367.50*

Physicians will receive clinic practice management payments one week after the expected payment of their processed time-based claims.

Claims received by Primary and Preventative Health Services are processed on Tuesdays, Wednesdays and Thursdays of each week with the weekly cut-off for Thursday at 4:30 p.m. When submitting within these time frames, claims are processed for payment on Friday of the following week. Claims not received within this period are processed on Tuesday the following week. Example:

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1 (W1)		Time-Claim Submission		Time Claim Submission	W1 Time Claims Processing
Week 2 (W2)					W1 Time Claims Payment
					W1 Administration Processing
Week 3 (W3)					W1 Administration Payment

### 5.5 Billing PCPCM on the Same Day as Excluded Services

Clinical services outside of traditional, longitudinal family practice must be billed using an FFS BA. For these services, time is not claimed. Instances of clinical services outside of the PCPCM include, for example:

- encounters with non-paneled patients during a defined walk-in clinic portion of the day
- encounters with patients in a long-term care or designated assisted living facility
- encounters with patients in hospital

Time cannot be claimed for providing out-of-basket services.

When providing in-basket services or encounters with non-paneled patients, including out-of-province patients, when a physician is mostly seeing their own paneled patients, claims should be submitted under their PCPCM BA with the encounter and time claimed. The monthly panel payment will not include these patients.

Physicians must exercise judgement if seeing non-paneled patients impedes access for paneled patients.

### 5.6 Clinical Teaching Time

Clinical teaching is a vital component of patient care, with physicians actively engaged in medical and interprofessional education, acting as a Supervising Physician.

For payment purposes, Clinical Learners include medical students, residents, Practice Ready

Assessment (PRA-AB) physicians, nurses and nursing students, nurse practitioners and nurse practitioner students, as well as midwives and midwifery students.

Supervising Physicians can bill for time when clinical teaching is concurrent with patient care provided by Clinical Learners:

- When patient care is provided in-person, the Supervising Physician must also be present
- When patient care is provided virtually, the Supervising Physician must be available in person, by phone or video conference in a timely matter
- The Supervising Physician must review the patient interaction and sign off on the medical record

Time-based codes are not payable for the Clinical Learner's time.

## 5.7 Patient No-Shows

Under the Ministerial Order, physicians cannot bill a patient directly for a missed appointment. This is to prevent "double recovery," where a physician does another task during that appointment time, bills the indirect time care code and bills the patient for the missed visit.

Where necessary, patients can be billed directly for a missed appointment if physicians do not claim time for the missed appointment. Records of these instances must be kept and must be auditable.

**TIP:** It is recommended that physicians engage in ongoing access improvement methods to reduce patient no-shows. See AMA's [Enhanced Access](#) resources for more information.

## 6.0 PANEL PAYMENTS

### 6.1 Complexity-Adjusted Panel Payments

The panel payment component of the Primary Care Physician Compensation Model (PCPCM) recognizes the continuous relationship between a family physician and their patients and acknowledges increased demands placed on physician practices by complex patients.

The Central Patient Attachment Registry (CPAR) is considered the source of truth for physician panels and submitting panels to CPAR is an eligibility requirement for entering the model (see [Section 2.0 Eligibility & Enrolment](#)). For information on how to enrol in CII/CPAR, see the [AMA's CII/CPAR Resources](#).

Panel payments for PCPCM are provided for each patient who is attached to a family physician's PCPCM panel (derived from CPAR) and calculated against health information that considers the patient's age, sex and Canadian Institute for Health Information Population Grouping Methodology (CIHI POP Grouper). To watch a short video on how the methodology works, see [Population Grouping Methodology](#). Additionally, a series of courses, developed by the Ontario Medical Association, explains CIHI Pop Grouper Methodology in detail and can be made available on request via [pcpcm@albertadoctors.org](mailto:pcpcm@albertadoctors.org).

When physicians care for patients with complex needs or multiple conditions, it can take more attention and resources than the average patient. These efforts are acknowledged with complexity-weighted panel payments - a patient with more complex care needs is associated with a higher payment. For more information, see [Appendix E: Annual Complexity Payments Table](#).

Only patients with an Alberta Health Care Insurance Plan number will be included in a physician's PCPCM panel and reflected in panel payments. In some cases, there may be a discrepancy between PCPCM panel count and the number of patients on CPAR list as CPAR includes paneled patients without an Alberta Health Care Insurance Plan number.

This compensation component is estimated to amount to 20% of a typical physician's insured billings.

## 6.2 Panel Payment Methodology

The Central Patient Attachment Registry (CPAR) is a provincial system that captures the confirmed relationship between a primary care provider and their paneled patients. This system is used to inform and calculate monthly PCPCM panel payments. For more information see the AMA's resource on [PCPCM: Complexity-Adjusted Panel Payments](#).

**Step 1:** The [CIHI POP Grouper](#) methodology assigns Alberta residents to a complexity category reflecting age, sex, diagnoses, and health care system usage. to determine what type of future system use can be expected for each patient.

A patient's complexity category will shift over time as they age, are diagnosed and how they use the health system. As patients change categories over time, this can lead to an increase or decrease for panel payments.

Patient diagnoses are the biggest predictor of which complexity category they are placed in. CIHI POP Groupers for individual patients refresh annually. If a patient fits within multiple categories, they will be categorized in the most complex category.

Patients are placed into one of sixteen complexity categories. In cases where the data does not exist to categorize a patient, they become part of a seventeenth category called “Unassigned”.

**Step 2:** Primary and Preventative Health Services then further separates the patients in each category based on age and gender

- Age: 0-1, 1-17, 18-34, 35-49, 50-64, 65-79, and 80+
- Sex: Male, Female, Unknown/Other (Male), reflective of the patient’s health care card information

**Step 3:** Patients are now assigned to a cell within the complexity-adjusted payment matrix to determine a payment calculation, using a modified formula from the Blended Capitation Model.

**Example Assignment:** Major Acute – Female - 18-34

Primary care-related costs for all patients within the complexity group are divided by the number of patients in that group. That value is prorated using the Blended Capitation Model formula amount

For a detailed look at the calculation matrix, see Appendix E: Annual Complexity [Payments Table](#).

**Step 4:** The value is then multiplied by the macro-allocation increases agreed upon by the Section of Family Medicine, Primary and Preventative Health Services and the Alberta Medical Association.

Panels uploaded to the physician’s electronic medical record in CPAR are refreshed monthly.

As of August 2025, once live on the PCPCM, physician panel data will no longer be updated in the AMA Member dashboard. Physicians who join the PCPCM can no longer use their AMA dashboard for up-to-date tracking of their PCPCM panel size or *Avg. Panel Payment per Patient (Annually)*. PCPCM physicians or their panel administrator should reference the Panel Submission Metrics Report in their CPAR Portal.

## 6.3 Payment to Physicians

Under a PCPCM BA, the average annual payment rate per paneled patient is \$70.25. This is for an Albertan of average complexity. The per patient payment can range from \$32.87 - \$136.73 depending on the patient’s age, sex and complexity. Physicians will be paid 1/12<sup>th</sup> of the patient’s annual rate each month. Therefore, the average monthly payment rate per patient is \$5.85 per month, paid retroactively on a monthly basis.

The EMR upload to CPAR occurs between the 1-21<sup>st</sup> of the month. Panel payment will occur in the following month, on the last Friday of the month, and will be reflected in the Statement of Account report. *See Exhibit 7.2 for a sample Statement of Account Changes. PCPCM panel payment – Jan 2025 denotes amount paid to physician for panel.* See [Section 6.6: Panel Uploads and Panel Payments](#) for more details.

A non-PCPCM physician’s average panel complexity payment per patient can be viewed in the [AMA Member Dashboard](#), *AMA Member login required*. If you’re a physician already on the model, this information will no longer be refreshed.

When a physician becomes aware that a patient has died or is no longer a resident of Alberta, the physician must update CPAR. See [Section 10.4: Written Notices to the Minister](#) for more details.

1	Dr. October Snowy	Statement Date
1	10021 Jasper Ave NW	Year Month Day
1	Edmonton AB T5J 1S6	2025 06 10
1		
1		
1		Method of Payment: EFT
1		SOA Reference <del>Num</del> : 880236100
Payee Dr. October Snowy		
Expected Payment Date: 2025/06/11		
	Total Amount:	1,040.10
-----		
Description	Reference Number	Date Business Arrangement Amount
Statement of Assessment	327722210	2025/06/10 6943810 34.87
Provider ID 4752-41008 Dr. October Snowy		34.87
PCPCM Administration - 6943810	332499600	2025/06/11 5.26
PCPCM PNL PMT Apr 2025 6943810	382496000	2025/06/11 999.97
-----		
Description	Amount	
Statement of Assessment	34.87	
PCPCM Administration - 6943810	5.26	
PCPCM PNL PMT Apr 2025 6943810	999.97	
Total Amount:	1,040.10	

*Exhibit 7.2: Sample Statement of Account Changes*

PCPCM PANEL PAYMENT SUMMARY					
Dr. T D Drlinkh Linker Clinic Edmonton AB		For the Period of 2025/04/01 - 2025/04/30			
Expected Payment Date: 2025/05/30					
Cohort Groups	Provincial Avg	Physician Avg	Total Amount Paid This Period	Total Amount Paid To Date	Number Of Patients
<b>Females</b>					
F UND 1	5.71	5.71	17.13	17.13	3
F 18- 34	5.99	5.84	596.22	596.22	102
F 50- 64	6.98	6.66	827.07	827.07	124
F 80+ UP	8.09	8.07	234.21	234.21	29
<b>Total of Females</b>			<b>\$1674.63</b>	<b>\$1674.63</b>	<b>258</b>
<b>Males</b>					
M 18- 34	3.93	3.99	726.98	726.98	182
M 65- 79	6.62	6.38	2,050.86	2,050.86	321
M 80+ UP	6.95	6.60	13.21	13.21	2
<b>Total of Males</b>			<b>\$2791.05</b>	<b>\$2791.05</b>	<b>505</b>
<b>Period Grand Total</b>			<b>\$4465.68</b>	<b>\$4465.68</b>	<b>763</b>

*Exhibit 8.1: Sample PCPCM Panel Payment Summary (PC001 Report)*

## 6.4 Panel Conflicts

When a patient is paneled to more than one CPAR panel, the patient is *in conflict*. This occurs when a patient is attached to more than one primary care provider.

For one year following the April 1, 2025, PCPCM launch, patients assigned to multiple CPAR panels will be included in physician compensation, paid at 100% value, as part of the monthly panel payments. During this grace period, physicians and their teams are expected to implement paneling processes that aim to keep the number of conflicts on their panel to a minimum.

As of April 1, 2026, when panel conflicts continue to exist, one or both physicians may not receive panel payments for that patient. It is important to note that the one-year grace period described above is from the PCPCM program launch, not the physician’s model start date.

Physicians using a PCPCM BA must commit to responsible and accountable CPAR panel management practices to maintain compliance with the model. This includes:

- Understanding how the EMR includes or excludes patients from the CPAR panel
- Ensuring the EMR panel is being properly uploaded to CPAR each month
- Ensuring only patients where the physician is the primary care provider are included in the CPAR panel upload, excluding patients seen only for episodic care like walk-in clinic visits or referred services

- Understanding how panel conflicts will impact panel payments beginning on April 1, 2026
- Working diligently to reduce panel conflicts
- Implementing clinic processes to keep panels clean
  - regularly confirming that the patient considers themselves to be part of the physician's panel
  - removing patients that are no longer under the physician's care

**TIP:** An overview of CPAR Conflicts for PCPCM users and how physicians and teams can get started on Conflict management processes ahead of April 1, 2026, is available [here](#).

Physicians participating in CII/CPAR will need to assign a CPAR Panel Administrator to access the CPAR Online Portal. Through the portal, the Panel Administrator can access [reports](#) which help physicians and teams track CPAR panel size, Conflicts and more. Each report is generated monthly on a per panel basis.

#### **CPAR Conflict Report**

This report lists patients on the Primary Provider's Panel that are also paneled to another primary provider's CPAR panel. If a patient is paneled to multiple CPAR panels, this will be flagged as a Conflict.

#### **CPAR Demographic Mismatch Report**

This report identifies where there are mismatches between the demographic information in the Primary Provider's Electronic Medical Record (EMR) and the Primary & Preventative Health Services Provincial Client Registry. It also indicates any deceased patients who have been included in the panel. To receive appropriate panel payments, it is important that physicians and their teams work to reduce these mismatches.

#### **CPAR Panel Submission Metrics Report**

This report displays details about the last six months of panel submissions including the number of patients uploaded from the EMR, demographic mismatches, attachment errors, total active attachments and conflicts.

For more information on interpreting reports and managing panel conflicts, see the AMA's [CII/CPAR Team Tool Kit for Primary Care](#).

## 6.5 Shared Panels

As the PCPCM is an individual physician funding model with each physician managing their individual patient panel, shared panels are ineligible under PCPCM. Each physician requires their own panel and PCPCM BA to participate.

Where two or more physicians share one CPAR panel, and one or more wishes to join the PCPCM, their shared panel can be split between them, provided the split results in a minimum of 500 patients on each physician's individual panel entering the PCPCM.

It is expected that patients will continue to see their primary care provider on whose panel they reside, the majority of the time. As part of ongoing PCPCM evaluation, panels and provider utilization will be reviewed periodically by PPHS.

If a group of physicians is sharing the care of a panel of patients, the Blended Capitation Model (BCM) may be a more desirable model. For more information, see the AMA's [Blended Capitation Model](#) resources.

## 6.6 Panel Upload Failures and Panel Payments

CPAR panel upload failures happen when the panel fails to upload from the EMR into CPAR. When a CPAR panel upload fails, PPHS will facilitate up to two manual panel payments using the most recent successful panel upload data.

Physicians should be aware that a maximum of two manual panel payments will be provided per issue. In the future, should a new issue arise, a manual panel payment will be provided.

If a physician experiences a failed upload, it is important to contact the EMR vendor to troubleshoot and fix the issue. If a failed upload is realized soon after the scheduled panel upload, the physician has an option to work with their EMR vendor to trigger a panel resubmission before the 20th of the month.

Common causes of panel upload failures are:

- time-stamp errors
- clinic configuration issues
- technical issues with EMR or CII/CPAR

### **Time-stamp Errors**

Occur when the clinic EMR is not reachable when panels are being submitted. This may be because the clinic's server was turned off at the time a CPAR upload was supposed to occur.

### Configuration Issues

Happens when a clinic changes something like their facility ID without informing eHealth. In this circumstance, the upload fails because the facility ID in the EMR does not match the facility ID CPAR is expecting.

In all cases, if a resubmission from the EMR does not resolve the failed panel issue, contact your EMR vendor and work with them to correct the issue as soon as possible.

## 7.0 TIME AWAY AND LOCUMS

**Host Physician (Host):** PCPCM physician who provides comprehensive, longitudinal care to a defined panel of patients. When taking time away from practice, they may enlist coverage from a Locum physician.

**Locum Physician (Locum):** Physician who provides care coverage to a defined panel of patients on behalf of a Host physician taking time away from practice.

When operating under the PCPCM, physicians may require a Locum to provide patient coverage for time away from practice for scenarios including:

- Illness
- Vacation
- Parental leave or caregiving
- Military deployment

For extended time away, Hosts can remain active in the PCPCM, but they must consider how their panel will be covered:

- Use Locum for coverage and/or
- Put CPAR panel “in transition”

A contract should be in place to set the Locum’s payment terms. For more information, see the AMA’s sample [PCPCM Locum Contract Guide](#).

Physicians must meet CPSA standards when taking time away from practice. For more information, see CPSA’s [Standard of Practice for Continuity of Care](#).

### 7.1 Options for Locums

When a Locum comes into a PCPCM practice to work in place of the Host, a decision will be made on the continuation of PCPCM payments. There are two options:

- Option 1: Locum submits claims using the Host’s PCPCM BA

- Option 2: Locum submits claims using the Locum’s FFS BA

Under either option, the Locum’s PRAC ID must be used in the PRAC ID field of claims submitted for services provided by the Locum. For claims, the Business Arrangement field determines where payment is sent and the Locum Arrangement field determines which submitter is used.

Under the PCPCM, physicians cannot use Locums to manage panel overflow, as this is considered “off-loading.” See [Section 2.0: Eligibility & Enrolment](#) for more details.

### **OPTION 1 (Regardless of the duration of coverage)**

The Locum will submit claims using the Host’s PCPCM BA and the Host continues to receive PCPCM payments.

- PCPCM discounted (in-basket) and non-discounted (out-of-basket) encounter claims payments will continue
- Time-based claim payments will continue
- Clinical administration payments will continue
- The Host’s patient panel remains active, and panel payments continue.

### **Summary Table**

<b>Compensation</b>	<b>Claims Process*</b>	<b>BA Usage</b>	<b>Payment Received By</b>
Encounter Claims	Locum Submits	Host’s PCPCM BA	Host
Time-Based Claims	Locum Submits	Host’s PCPCM BA	Host
Clinical Administration	Calculated by PPHS	N/A	Host
Panel	Calculated by PPHS via CPAR	N/A	Host

\*Primary and Preventative Health Services

To submit claims, see the claim field requirements on the Alberta Government’s [Physician Resource Guide](#), Payment Option 1.

- The PCPCM BA of the Host is placed in the Business Arrangement field
- Locum BA field is left blank

See [Exhibit 9.1](#) and [Exhibit 10.1](#) for visuals of claim submissions and sample statements.

*Exhibit 9.1: Claim Example of Option 1*

As the Host’s submitter is used, the Locum BA field is left blank. The screenshot below is an example Statement of Assessment showing how to determine if it is the Locum who provided the service. The Locum’s Prac ID will appear on the statement.

Chart Number	PHN	Claim Number	Service Start Date	Service Code	Claimed Amount	Assessed Amount	Mod Code	Result Code	Exp Code	Exp Code	Registration Number	RC
		4451-31008	2025/05/02	PC004	0.00	722.70		APLY				
		94924-6000	2025/05/01	03.03A	0.00	27.55		APLY	99C			
Total Amount to be Paid					750.25							
Total Amount (RVRSLS)					0.00							

*Exhibit 10.1: Sample Statement of Assessment - Locum Scenario*

**OPTION 2 – Less than 28 Days**

If requiring coverage for less than 28 calendar days, panel payments continue to be paid to the Host and the Locum will receive Fee-for-Service billing.

**Summary Table**

Compensation	Claims Process	BA Usage	Payment Received By
Encounter Claims	Locum Submits	Locum FFS	Locum
Time-Based Claims	N/A	N/A	N/A
Clinical Administration	N/A	N/A	N/A
Panel	Calculated by PPHS via CPAR	N/A	Host

\*Primary and Preventative Health Services (process previously managed by Alberta Health)

## OPTION 2 – More than 28 Days

If requiring coverage for 28 calendar days or more, the Host must pause their PCPCM panel payments by changing their CPAR panel to “in transition” status. The notification to the minister should occur at least 10 business days prior and the panel should be placed in transition at the beginning of Locum coverage or as soon as it is known the Host will be away.

Utilize the “In Transition” option on the CPAR Panel Request Form found on the [CPAR Forms and Guides](#) webpage to place the panel in transition. This will pause the panel payments.

When Locum coverage ends, or the Host physician resumes care of the panel, use the same form to re-activate the CPAR panel. In the comment section, state that locum coverage has ended, or the Host physician has resumed care, and the panel should be re-activated.

For additional information on Panels in Transition, refer to AMA’s webpage on [CII/CPAR Provider Absences and Panels in Transition](#). It is noteworthy that patients cannot be added to a panel once placed in transition.

In this option, the Locum is not entitled to bill for time and clinical administration payments will cease.

## Summary Table

Compensation	Claims Process	BA Usage	Payment Received By
Encounter Claims	Locum Submits	Locum FFS	Locum
Time-Based Claims	N/A	N/A	N/A
Clinical Administration	Paused	N/A	N/A
Panel	Paused	N/A	N/A

## If the Locum has their own submitter:

- Locum submits claims using their FFS BA in the “BA field”
- Locum will receive Fee-for-Service claim payments

To submit claims, see claim field requirements in the [Physician Resource Guide](#), Payment Option 3., Payment Option 3.

**If Locum does not have their own submitter:**

- Locum submits claims using their FFS BA in the “BA field” and the Host’s BA (FFS or PCPCM) in the “Locum BA field”
- Locum will receive Fee for Service claim payments

To submit claims, see claim field requirements in the [Physician Resource Guide](#), Payment Option 4.

## 8.0 EXCLUDED SERVICES

Services which are not included in the list of PCPCM in-basket codes (see [Section 4.2](#)) are considered out-of-basket (see [Section 8.2](#)) but can be claimed using a PCPCM BA, paid at 100% of the FFS rate. Services which are not included in the list of PCPCM in-basket codes (see [Section 4.2](#)) are considered out-of-basket (see [Section 8.2](#)) but can be claimed using a PCPCM BA, paid at 100% of the FFS rate. As the full rate is provided, PCPCM’s time-based codes cannot be claimed.

Where care is provided outside the PCPCM, Fee-for-Service and Alberta Health Care Insurance Plan billing rules and guidance on delivering uninsured services apply. For more information, see AMA’s [Guide to Uninsured Services](#) (*AMA member login required*) and [8.1 Complexity Modifiers for In-basket Services](#).

### 8.1 Complexity Modifiers for In-basket Services

For PCPCM’s in-basket services, the following complexity modifiers, are not billable:

- o CMGP01 - CMGP10
- o CMXC30

If a physician submits a claim with these modifiers while using their PCPCM BA, the system will ignore the code.

For more details on complexity modifiers use, see [Section 4.4 Complexity Modifiers for Out-of-Basket Services](#).

### 8.2 Out-of-basket Services

In the following scenarios, encounters and procedures are considered out-of-basket and physicians should use their FFS BA:

- Services provided in AHS facilities
- Services done under contract with AHS
- MAID

A PCPCM BA can be used for out-of-basket service claims for patients seen in the designated clinic. See [Section 4.3: Out-of-Basket Health Service Codes](#) for more details.

### 8.3 Services to Non-paneled Patients

In the following circumstances, encounters and procedures for non-Paneled patients cannot be billed with a PCPCM BA but are payable at 100% FFS rate using a FFS BA:

- Walk-in clinic with predominantly non-paneled patients
- Consult clinic with predominantly non-paneled patients

Where occasional non-paneled patients are seen throughout the day, the physician's PCPCM BA can be used, and time can be claimed (see Section [5.0 Billing for Time](#)). If a physician is cross-covering paneled patients for a colleague in the clinic, the physician providing services can bill using their PCPCM BA.

### 8.4 Workers Compensation Board (WCB)

Services that are covered under WCB are considered third-party billing and should be billed directly to WCB using the physician's WCB billing number. Time spent providing services related to WCB may not be claimed using the PCPCM time-based or after-hours codes. On a day where a physician sees paneled patients for PCPCM-eligible services and also provides WCB services, time spent on WCB activities must be deducted from time-based claims.

For more information, see the [Alberta Billing Information Guide](#) and the [AMA's WCB Compensation and Billing Support page](#).

### 8.5 Services to Residents of Other Provinces and Territories with a Valid Health Care Coverage Card

Patients without a valid Alberta health care coverage card, but with a valid health care card from another province, do not count toward the PCPCM panel. When these patients are present at the clinic, when the physician is mostly seeing PCPCM paneled patients, claims for encounters and time can be claimed under PCPCM.

When these patients are seen at the clinic during a time not usually dedicated to paneled patients (e.g., a walk-in clinic open to the community), the physician will need to submit claims under an FFS BA and cannot claim the time using a PCPCM BA.

## 8.6 Services to Residents of Alberta or Other Provinces Without a Valid Health Care Coverage Card

Patients without an Alberta Health Care Insurance Plan number will not be included in the PCPCM panel count and claims cannot be submitted with a PCPCM BA.

For more information, see the Alberta Government's [Alberta Health Bulletin Gen 145](#) and [Physician's Resource Guide](#).

## 8.7 Services to Residents of Other Countries

Patients from other countries without an Alberta Health Care Insurance Plan number will not be included in the PCPCM panel count and claims for encounters and procedures cannot be submitted with a PCPCM BA. Physicians are advised to charge these patients directly for services provided.

For more information, please refer to the Alberta Government's [Alberta Health Bulletin Gen 145](#).

## 8.8 Other Uninsured Services

As with the Fee-for-Service funding model, uninsured services not covered by the Alberta Health Care Insurance Plan cannot be submitted with a PCPCM BA and should be billed to the patient or to the third party requesting the information.

Time spent providing uninsured services may not be submitted using the PCPCM time-based Health Service Codes (HSCs). For more information, see the [AMA's Uninsured Fee Guide](#) (*AMA member login required*).

Uninsured services not covered by the Alberta Healthcare Insurance Program:

- Advice by telephone or other telecommunication methods except as specified under specific Health Service Codes or for telehealth services
- Ambulance services except ambulance detention time (HSCs 13.99K, 13.99KA, 13.99KB)
- Anesthetic materials
- IV sedation for dental procedures when patient is not an inpatient or registered outpatient of a hospital setting
- Transfer of medical records
- Acupuncture
- Services and procedures which are not medically required
- Artificial insemination
- Chelation therapy which is not provided to a hospital inpatient for treatment of lead poisoning

- Gamete intrafallopian transfer
- In vitro fertilization
- Sperm transfer
- Eye surgery for the sole purpose of eliminating the need for eyeglasses or contact lenses
- Cosmetic liposuction
- Breast enlargement for purposes other than those specifically listed in the schedule
- Oculo-visual examinations for residents aged 19-64 years
- Telephone prescription renewals
- Cosmetic procedures or services
- Drugs/agents
- Medical appliances
- Travel advice and immunizations
- Some de-insured procedures (e.g., wart removal, circumcision)
- Completing third party forms, letters, reports or those that relate to an uninsured service
- Services a physician provides to family, spouse or any person dependent on the physician for support in accordance with the Alberta Health Care Insurance Regulation
- Medical testimony in court except psychiatric opinion at psychiatric review panel under the Mental Health Act
- Secretarial or reporting fees
- Travel time of the physician to see a patient
- Stand-by time
- Services requested by a third party
  - Examinations or certification for adoptions
  - Medical examinations to indicate fitness to attend camp
  - Autopsies
  - Employment examinations and reports
  - Examinations and reports requested under the auspices of the Child Welfare Act
  - Immigration requirements
  - Insurance/disability reports and forms
  - Examinations and reports for judicial purposes (e.g., requested by police)
  - Medical-legal reports requested by patients or by lawyers on behalf of patients except for HSC 03.01MT
  - Examinations and forms relating to: motor vehicle licensure, participation in sports, university or other school requirements or passport and visa applications
- Pre-travel assessments, counseling or administration of vaccines or drugs for travel purposes to reduce the patient's risk of acquiring an illness, or for prevention of communicable diseases not endemic to Canada
- Administration of vaccines such as Hepatitis A and B, unless specifically otherwise communicated by Primary & Preventative Health Services

## 9.0 NEW PHYSICIANS & RECENT MEDICAL GRADUATES

Eligibility criteria for new-to-practice physicians in Alberta will differ from currently practicing family physicians and rural generalists. New-to-practice physicians include those who have:

- completed residency in the last 6 months
- not yet been licensed to practice in Alberta (e.g., new to province or new to country)

New-to-practice physicians can enrol in PCPCM before reaching the model minimum of 500 patients on their PCPCM panel. They must already be in CPAR when applying.

Once enrolled, new-to-practice physicians will have a 6-month grace period to panel a minimum of 500 patients. Should the physician not reach 500 paneled patients, they will receive notice from Primary and Preventative Health Services and be removed from the PCPCM. For more information, see [Section 2.4 Withdrawal from the PCPCM](#).

While building their PCPCM panel, new-to-practice physicians must comply with all other rules and rates defined in the Ministerial Order. See [Section 1.4](#) for more information.

**TIP:** Recent graduates interested in joining the PCPCM can contact the ACTT Support Team at [pcpcm@albertadoctors.org](mailto:pcpcm@albertadoctors.org) to be connected with a PPHS representative.

## 10.0 ADMINISTRATION

### 10.1 Audit Authority

Physicians receiving payment through the PCPCM must be compliant with the Alberta Health Care Insurance Act, which forms the governing legislation of the Alberta Health Care Insurance Plan.

Physicians are subject to the auditing authority of the Alberta government under the Alberta Health Care Insurance Act and are responsible for all claims submitted to the Alberta Health Care Insurance Program under their Practitioner Identification (PraID).

For more information, please refer to Alberta's Health Professional and Delivery Resources [Audit and Compliance Assurance](#).

### 10.2 Adequate Records & Documentation

All claims must be supported by an adequate medical record consistent with CPSA's Patient Record Standards of Practice. For more information, see the CPSA's [Patient Record Content](#).

Physicians must ensure that medical records and other documentation support the claims made for time and encounters. Documentation must be available upon request in accordance with the Alberta Health Care Insurance Act.

As with the Fee-for-Service model, it is recommended that physicians record the time spent with each patient using encounter notes. If providing direct patient care, this time can be documented directly in the encounter note. When completing indirect care, physicians will have to find a method that works best for them. Options include:

- create a fictitious patient (e.g., "PHYSICIAN-BILLING") where start and end times can be recorded
- use a time-management app that can produce printable or downloadable records
- use a notebook where pages cannot be added or removed

This information should be stored as long as billing information is kept. For more information, see CPSA's Standard on [Patient Record Retention](#).

Patient care provided under other payment models, like FFS, must be clearly documented and demonstrate there is no overlap with time claimed under the PCPCM.

### 10.3 Alberta Healthcare Insurance Program Facility Number

A new facility number or designation is not required for PCPCM. The facility number for fee-for-service claims and PCPCM claims can be the same. Physicians will be required to submit Fee-for-Service claims under their FFS BA and their PCPCM patients under their PCPCM BA.

### 10.4 Written Notices to the Minister

Section 7.0 (pages 7-8) of the [Ministerial Order](#) states that PCPCM physicians must notify the Minister in the following scenarios, with various required steps and methods for adequate notice that may require Alberta Government business forms or an update to the physicians' CPAR panel. Business forms and instructions can be found on the Alberta Government [website](#).

#### **Physician-Level (Administration)**

- change to designated clinic location – see [Section 2.4: Moving Facilities](#)
- withdrawal from the PCPCM – see [Section 2.5 Withdrawal from the PCPCM](#)

#### **Paneled Patient-Level (Monthly Panel Payments)**

- patient death
- patient no longer lives in Alberta

#### **Paneled Patient Death**

- A change in CPAR or routine completion of patient's Medical Certificate of Death is considered adequate notice.
- If the patient dies and the primary physician is not made aware immediately (e.g., death in hospice), the physician will receive an eNotification through CII and/or patient will appear in the CPAR demographic mismatch report.
- Update the EMR record and de-panel the patient, resulting in a change to CPAR.

#### **Patient no Longer lives in Alberta**

- A change in CPAR is considered adequate notice.
- When notified that a patient has relocated out of Alberta, appropriate documentation must be entered in the patient's chart, including notes or chart transfers to the out-of-province physician, resulting in a change in CPAR.

Physicians and teams should also ensure these activities are done in alignment with CPSA's Standards of Practice.

## **APPENDIX A: DEFINITIONS**

### **Alberta Health Care Insurance Act**

This Act establishes the administrative structure for a plan that provides Alberta residents with access to a variety of publicly funded health services.

### **Alberta Health Care Insurance Plan**

Provides eligible Alberta residents with full coverage for medically necessary physician services, including select dental and oral surgical health services.

### **Alberta Health Services (AHS)**

Alberta's integrated health system, responsible for delivering health services to more than 4.5 million people living in Alberta, as well as occasionally to some residents of other provinces and territories.

### **Business Cost Program (BCP)**

Part of the Clinical Stabilization Initiative funding intended to support community practices where increased business costs are having an impact on stability and attractiveness.

### **Canadian Institute for Health Information Population Grouping Methodology (CIHI POP Grouper)**

The CIHI POP Grouper contains a case-mix classification that profiles each person in the population using person-level demographic and clinical information. These profiles are then used to help predict the population's health care needs and costs. All persons in the population

over a given time period, including healthy persons and persons who have not used the health system, are represented in the CIHI POP Grouper.

**Clinic Practice Management**

Policies and procedures that guided practice in the former regions and boards continue to remain in effect until replaced by an approved AHS clinical practice support document (e.g., policy, procedure, standard, or guideline).

**Clinical Alternative Relationship Plan (cARP)**

A physician compensation model that provides an alternative to the Fee-for-Service model. It compensates physicians for providing a set of clinical services at defined facilities to a target patient population. *Note: cARPS are sometimes referred to as ARPs.*

**Community Clinic-Based Practice**

Primary Health Care clinic that focuses on wellness, social supports and culturally safe and respectful care Albertans. It aims to be population health-driven, seamlessly integrated, team-centered, and technology-supported.

**Community Information Integration (CII)**

A system that transfers select patient information between community Electronic Medical Records (EMRs) and other members of the patient's care team through Alberta Netcare.

**Central Patient Attachment Registry (CPAR)**

A provincial system that captures the confirmed relationship of a primary provider and their paneled patients.

**Confirmed Relationship**

Confirmed identification of primary care provider with a patient that is agreed upon by both parties and documented in patients' health records.

**Conformed EMR**

Electronic Medical Record system that adheres to all conformance requirements set by the Primary & Preventative Health Services Conformance Team, used in relation to CII/CPAR functionality.

**Cumulative Time**

Individual time segments which may be continuous or interrupted. Cumulative time is calculated by adding the total time spent delivering patient care as identified in the description of the Health Service Code, over the course of the day and dividing the total time by the time units specified in the Health Service Code to determine the appropriate number of calls.

**Demographic Mismatch Report**

Identifies where there are mismatches between the demographic information in the Primary Provider's Electronic Medical Record (EMR) and the Primary & Preventative Health Services Provincial Client Registry. It also indicates any deceased patients who have been included in the panel. It is produced monthly.

**Direct Patient Care**

Time spent on a patient encounter.

**Electronic Medical Record (EMR)**

Electronic files that a doctor or other provider uses instead of paper files stored on shelves.

**Expression of Interest (EOI)**

A document intended for physicians to indicate their interest in PCPCM, enabling the collection of relevant information to provide key resources and communications for those interested.

**Facility Number**

Physicians are required to designate a physical location where services to patients are provided. Each EMR stores the facility number for each provider for billing purposes, created and managed by the physician using WellNet.

**Fee-for-Service (FFS)**

Alberta's default compensation option for physicians.

**In-Basket**

Services and encounter types which are billable/payable through the PCPCM.

**Indirect Care**

Time spent caring for a patient while not in a patient encounter. (e.g., reviewing lab results, writing referrals, reviewing discharge plans).

**Longitudinal Family Medicine (Longitudinal Care)**

Longitudinal family medicine is a model of care in which family physicians establish enduring, continuous relationships with patients over time, providing comprehensive, person-centered care across all life stages and health needs. It emphasizes continuity, fostering trust and a deep understanding of the patient's physical, psychological and social context within the broader community.

**Medical Assistance in Dying (MAID)**

The administration, prescribing, or provision of medications by a regulated member, within the parameters set out by the legislation, to a requesting person to cause the person's own death.

**New-to-practice Physicians**

Graduates who have completed their residency in the last 6 months or physicians from another province or country not yet licensed to practice in Alberta.

**Out-of-Basket**

Medical services found in the [Schedule of Medical Benefits \(SOMB\)](#) that are not listed in the PCPCM list of in-basket of services.

**Panel**

A patient panel, or roster that lists the unique patients that have an established relationship with a physician. There is an implicit or explicit agreement that the identified physician will provide primary care services.

**Panel Management**

A proactive approach used by primary care teams to offer care to a defined panel of patients attached to a physician or nurse practitioner.

**PCPCM Business Arrangement Number (PCPCM BA)**

A unique seven-digit number that identifies a contract holder, service provider and payee for Primary and Preventative Health Services claims. It is required for all practitioners registered to submit claims and get reimbursed for their services under the PCPCM.

**PCPCM Ministerial Order (MO)**

[Ministerial Order](#) (MO) 510-2025, establishing the PCPCM Clinical Alternative Relationship Plan. Issued by the Minister of Health, under legal authority to implement policies, make decisions and manage administrative matters without requiring new legislation. Upon model entry, physicians must adhere to the rules and rates defined in the MO.

**PCPCM Panel**

All patients in an individual physician's CPAR panel who have an Alberta Health Care Insurance Plan Number. Uploaded monthly from an EMR to CPAR, a [PCPCM Panel](#) informs the PCPCM application process, ongoing PCPCM eligibility and monthly panel payments.

**Practitioner Identification Number (PraID or Pract ID #)**

All physicians require this 9-digit number to practice in Alberta.

**Primary Care Physician Leaders**

Representatives from the [Section of Family Medicine \(SFM\)](#), the [Section of Rural Medicine \(SRM\)](#) and [Primary Care Network Physician Leads Executive \(PCN PLE\)](#).

**Primary Care Network (PCN)**

Primary Care Networks (PCNs) are the most common model of team-based primary health care delivery in Alberta. PCNs aim to provide comprehensive, collaborative primary health care services to the local communities they serve, working together with teams of health care professionals, such as nurses, dietitians and pharmacists.

**Primary & Preventative Health Services Provincial Client Registry (PCR)**

Centralized repository that links diverse information sources within and across health organizations and jurisdictions in Alberta. It contains demographic information and coverage eligibility for all patients who have interacted with or received medical care in the province.

**Process Development**

Includes having clinic teams review the patient panel lists and reach out to offer care (virtually or in person). This is particularly of importance for at-risk, vulnerable and complex patients who may hesitate to, be unaware of, or be afraid to access needed care.

**Rural, Remote, Northern Program (RRNP)**

Part of the Clinical Stabilization Initiative, supporting physicians who practice in underserved areas in Alberta. The [program's](#) primary objective is to provide financial incentives/funding to drive physician recruitment and retention in rural, remote and northern Alberta communities and to ensure equitable health services for all Albertans.

**Sex**

In the context of the complexity model informing panel payment amounts, a data field with categories of Male, Female, Other and Unknown. For the purposes of PCPCM panel payments, Female is classified as *Female* while all other categories are classified as *Male*.

**Standards of Practice**

The College of Physicians and Surgeons of Alberta (CPSA) regulates the practice of medicine in Alberta, providing [standards](#) of professionalism and ethics expected from physicians and physician assistants. Developed with patient safety and practice support in mind, standards are developed and updated in consultation with the profession, Albertans, the Minister of Health and applicable partners.

**Tray Fee**

A fee that is meant to compensate for some expenses related to providing an insured service. Tray fees are implicit, meaning that they will be applied to eligible procedures when provided in eligible locations. Tray fees under the PCPCM will be paid at 100% value in accordance with the Governing Rules of the [Schedule of Medical Benefits \(SOMB\)](#).

### Uninsured Services

Services performed for third parties, government departments and administrative or clinical services not paid for by Primary and Preventative Health Services. See AMA's [Guide to Uninsured Services](#) (AMA member login required).

## APPENDIX B - BACKGROUND & PRINCIPLES OF THE PCPCM

The Primary Care Physician Compensation Model (PCPCM) was developed by the AMA Section of Family Medicine and Primary & Preventative Health Services. It is a voluntary compensation option for Family Physicians and Rural Generalists who deliver comprehensive, longitudinal care to a defined panel of patients.

### PCPCM Guiding Principles

The PCPCM's guiding principles outline what the payment model seeks to support and achieve for patients, physicians and the Alberta health care system:

**Recognition of Expertise:** Compensating physicians for managing patient complexity, indirect Care and essential practice management activities. This approach is an important recognition of the extensive training, experience and leadership that primary care physicians bring to Alberta's health care system.

**Improved Recruitment and Retention:** The PCPCM is designed to make Alberta a more attractive destination for physicians, residents and medical students. By providing a modernized compensation option, the model seeks to ensure a stable and growing health care workforce for the future.

**Physician Choice:** The PCPCM will not fit every practice style and is entirely optional. Some practices will be better suited to other payment models, such as Fee-for-Service or other Clinical Alternative Relationship Plans (cARPs).

**Patient's Medical Home (PMH):** Physicians are supported to offer longitudinal, comprehensive, high-quality and accessible care to a defined panel of patients in a community-based clinic. Through the PMH, Albertans will benefit from improved primary care.

**Patient-Centered Care:** The ability to offer patient-centered care is enhanced through strong patient-provider relationships and improved continuity. Physicians are compensated for time spent on direct and indirect care. Through the addition of a time-based component, the model

acknowledges that primary care requires different time intensities based on individual patient and physician contexts.

**Enhanced Health Outcomes:** Comprehensive, longitudinal care is associated with improved health outcomes for patients. Physicians are compensated for managing patient complexity which allows for proactively focusing on wellness and prevention in addition to improving capacity to manage chronic disease. Patients benefit from proactive management and earlier intervention strategies.

**Equity:** The PCPCM improves equity for patients across the province to access comprehensive, longitudinal care. Additionally, the compensation option values the critical role of Longitudinal Family Medicine as a foundation of the health care system. Rates developed for this model are competitive with neighbouring provinces.

## The Patient's Medical Home (PMH)

A Patient's Medical Home (PMH) is the practice patients feel most comfortable attending for their primary care needs. The optimized PMH is the foundation of an integrated health care system in Alberta.

The PMH emphasizes the role of an interdisciplinary team that provides high-quality, comprehensive, compassionate and timely care for patients and their family throughout their life. It is a vision to which all family practices can aspire and reflects the essential role that Family Physicians and their practices have in the health care system.

Adopting the PMH aims to:

- Increase patient and provider satisfaction
- Improve quality of care
- Reduce costs
- Reduce hospitalizations

The PMH, in accordance with the College of Family Physicians of Canada (CFPC) Vision outlines three core themes:

- Foundations: Supports necessary for the successful implementation of a PMH
- Functions: Types of care which are central to a PMH
- Ongoing Development: Ways in which the Patient's Medical Home can improve over time

Under these core themes are ten pillars central to the PMH vision:

## Foundations

1. Administration and Funding: Financial and governmental support, governance, leadership, management
2. Appropriate Infrastructure: Physical space, human resources, electronic medical records, other digital supports
3. Connected Care: Practice integration with other settings through information technology

## Functions

4. Accessible Care: Timely access, virtual access, team-based approaches, accessible care
5. Community Adaptiveness and Social Accountability: Accountable to the community and meet needs through interventions at patient, practice, community, policy level
6. Comprehensive Team-Based Care with Family Physician Leadership: Services offered by interprofessional team who communicate well with each other
7. Continuity of Care: A responsible provider on the journey with the patient who knows the patient's health changes over time
8. Patient- and Family-Partnered Care: Responding to the needs of patients and their families

## Ongoing Development

9. Measurement, Continuous Quality Improvement, and Research: Progress through performance measurement and continuous quality improvement
10. Training, Education, and Continuing Professional Development: Emphasis on training and education, sharing the expertise of the Family Physician with the broader health care community

More information: [A New Vision for Canada: Family Practice – The Patient's Medical Home.](#)

## APPENDIX C: IN-BASKET VISIT CODES

This appendix outlines the PCPCM's Health Service Codes (HSCs) with descriptions in numerical order. For more information, see AMA's [Fee Navigator](#).

Visit HSCs	Description
03.01AD	Diagnostic interview and evaluation, unqualified {Advice to a patient or their agent (agent as defined in the Personal Directives Act) via telephone, secure email or videoconference}

03.01B	Diagnostic interview and evaluation, unqualified {Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 0700 to 1700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.}
03.01BA	Diagnostic interview and evaluation, unqualified {Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.}
03.01BB	Diagnostic interview and evaluation, unqualified {Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel any day 2200 to 0700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.}
03.01C	Diagnostic interview and evaluation, unqualified {Telehealth assistance service}
03.01CC	Telephone advice and counselling to a patient or their agent (agent as defined in the Personal Directives Act) regarding the COVID-19 vaccine
03.01LG	Diagnostic interview and evaluation, unqualified {Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 0700 to 1700 hours}
03.01LH	Diagnostic interview and evaluation, unqualified {Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours}
03.01LI	Diagnostic interview and evaluation, unqualified {Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure

	videoconference consultation, referring physician, any day 2200 to 0700 hours}
03.01LJ	Diagnostic interview and evaluation, unqualified {Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours}
03.01LK	Diagnostic interview and evaluation, unqualified {Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours}
03.01LL	Diagnostic interview and evaluation, unqualified {Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, any day 2200 to 0700 hours}
03.01N	Diagnostic interview and evaluation, unqualified {Management of anticoagulant therapy to include ordering necessary blood tests, interpreting results, adjusting the anticoagulant dosage as required}
03.01NG	Diagnostic interview and evaluation, unqualified {Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient}
03.01NH	Diagnostic interview and evaluation, unqualified {Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via

	telephone or other telecommunication methods, in relation to the care and treatment of a patient}
03.01NI	Diagnostic interview and evaluation, unqualified {Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient}
03.01NM	Diagnostic interview and evaluation, unqualified {Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient}
03.01O	Diagnostic interview and evaluation, unqualified {Physician or Nurse Practitioner to Physician secure E-Consultation, consultant}
03.01R	Diagnostic interview and evaluation, unqualified {Physician to Physician secure E-Consultation, referring physician}
03.01S	Diagnostic interview and evaluation, unqualified {Physician to patient secure electronic communication}
03.01T	Diagnostic interview and evaluation, unqualified {Physician to patient secure videoconference}
03.02A	Diagnostic interview and evaluation, described as brief {Brief assessment of a patient's condition requiring a minimal history with little or no physical examination}
03.03A	Diagnostic interview and evaluation, described as limited {Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient - in office.}
03.03B	Diagnostic interview and evaluation, described as limited {Prenatal visit - in office.}

03.03C	Diagnostic interview and evaluation, described as limited {Routine post-natal office examination}
03.03CV	Diagnostic interview and evaluation, described as limited {Assessment of a patient's condition via telephone or secure videoconference.}
03.03N	Diagnostic interview and evaluation, described as limited {Home visit - first patient} <<Home Visits>>
03.03P	Diagnostic interview and evaluation, described as limited {Home visit - second/subsequent patients}
03.04A	Diagnostic interview and evaluation, described as comprehensive {Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient - in office.}
03.04B	Diagnostic interview and evaluation, described as comprehensive {Initial prenatal visit requiring complete history and physical examination}
03.04I	Diagnostic interview and evaluation, described as comprehensive {Comprehensive visit, including completion of form, required for admission to a regional health authority addiction residential treatment centre}
03.04K	Diagnostic interview and evaluation, described as comprehensive {Comprehensive geriatric assessment, first full 90 minutes}
03.04M	Diagnostic interview and evaluation, described as comprehensive {Pre-operative history and physical examination in relation to an insured service}
03.04N	Diagnostic interview and evaluation, described as comprehensive {Comprehensive evaluation including completion of forms to determine capacity as defined by the Personal Directives Act (PDA) (RSA 2007 s9(2)(a))}
03.04Q	Diagnostic interview and evaluation, described as comprehensive {Post surgical cancer surveillance examination}

03.05I	Other diagnostic interview and evaluation {Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof - in office or a patient's home}
03.05JA	Other diagnostic interview and evaluation {Formal, scheduled, multiple health discipline team conference, full 15 minutes or major portion thereof for the first call when only one call is claimed} <With para-medical personnel regarding the provision of health care where social and other issues are involved>
03.05JB	Other diagnostic interview and evaluation {Formal, scheduled family conference relating to a specific patient, per 15 minutes or major portion thereof}
03.05JH	Other diagnostic interview and evaluation {Family conference via telephone, in regards to a community patient}
03.05JN	Other diagnostic interview and evaluation {Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain, when discussion occurs on behalf of a specific patient per full 5 minutes to a maximum of 6 units in a 30-minute period}
03.05JQ	Other diagnostic interview and evaluation {Family conference with relative(s) via telephone in connection with the management of a patient with a psychiatric disorder}
03.05JR	Other diagnostic interview and evaluation {Physician telephone call directly to patient, to discuss patient management/diagnostic test results}
03.05LA	Other diagnostic interview and evaluation {Group session, multiple patients, where a physician is involved in providing care and teaching to patients in attendance}
03.05O	Other diagnostic interview and evaluation {Direct management, reassessment, education and/or general counselling of a patient with chronic pain, per 15 minutes or portion thereof}

03.05T	Other diagnostic interview and evaluation {Formal, scheduled, professional interview relating to the care and treatment of a palliative care patient with other physicians, family, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed}
03.05U	Other diagnostic interview and evaluation {Second and subsequent physician attendance at formal, scheduled, professional interview relating to the care and treatment of a palliative care patient with other physicians, family and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed}
03.05V	Other diagnostic interview and evaluation {Formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes}
03.05X	Other diagnostic interview and evaluation {Formal, scheduled, professional interview with relative(s) relating to the care and treatment of a patient with chronic pain on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed}
03.07A	Consultation, described as limited {Minor consultation - in office}
03.07B	Consultation, described as limited {Repeat consultation}
03.08A	Consultation, described as comprehensive {Comprehensive consultation - in office}
03.08CV	Consultation, described as comprehensive {Comprehensive consultation via telephone or secure videoconference}
03.08F	Consultation, described as comprehensive {Formal, comprehensive consultation, for a patient with chronic pain, full 60 minutes or major portion thereof for the first call when only one call is claimed}

07.57B	Application of other wound dressing {Subsequent treatment - minor burns - dressing and/or debridement}
08.19CW	Other psychiatric evaluation and interview {Telephone or secure videoconference with a patient for scheduled psychiatric treatment or for a palliative care or a chronic pain visit by an eligible physician, per 15 minutes or major portion thereof.}
08.19D	Other psychiatric evaluation and interview {Professional interview with relative(s) in connection with the management of a patient with a psychiatric disorder, but without the patient being present during the interview, per 15 minutes or major portion thereof}
08.19F	Other psychiatric evaluation and interview {Formal, scheduled, professional conference related to the care and treatment of a psychiatric patient with other physician(s), and/or direct therapeutic supervision of, allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care, per 15 minutes or major portion thereof}
08.19G	Other psychiatric evaluation and interview {Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof - in office.}
08.19H	Other psychiatric evaluation and interview {Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of a psychiatric patient, on behalf of a specific patient, per 15 minutes or major portion thereof}
08.19J	Other psychiatric evaluation and interview {Formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care}

08.19K	Other psychiatric evaluation and interview {Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient}
08.44A	Group therapy {Group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed}
08.45	Family therapy {Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed - in office.}
13.59V	Immunization and administration of COVID-19 vaccine
13.59VA	Prolonged COVID-19 vaccination - physician time only, greater than 10 minutes
13.82A	Ultraviolet light therapy {Psoralen ultraviolet A treatment, ultraviolet B or narrow-band ultraviolet B treatment}
13.99J	Other diagnostic interview and evaluation {Medical emergency detention time, per 15 minutes}
98.12S	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Non-surgical treatment, cryotherapy} <<Condylomata acuminata>>

## APPENDIX D: IN-BASKET PROCEDURE CODES

This appendix outlines the PCPCM's Health Service Codes (HSCs) with descriptions in numerical order. For more information, see AMA's [Fee Navigator](#).

Procedure HSCs	Description
03.12A	Measurements and manual examination of nervous system and sense organs {Intraocular pressure measurement, unilateral or bilateral}
07.57A	Application of other wound dressing {Initial treatment - minor burn}

10.16B	Insertion of other vaginal pessary {Pessary removal, adjustment and/or reinsertion}
11.71A	Removal of intrauterine contraceptive device (IUD) {Removal of intrauterine contraceptive device (IUD)}
12.21	Removal of intraluminal foreign body from ear without incision
13.42A	Immunization for allergy {Desensitization treatments with allergy serums}
13.53B	Injection of steroid {Intralesional injection(s) of steroid}
13.59A	Injection or infusion of other therapeutic or prophylactic substance nec {Intramuscular or subcutaneous injections}
13.59J	Injection or infusion of therapeutic or prophylactic substance NEC {Injection with local anesthetic of myofascial trigger points}
13.59O	Injection or infusion of therapeutic or prophylactic substance NEC {Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age}
13.99BA	Other miscellaneous diagnostic and therapeutic procedures NEC {Periodic Papanicolaou Smear for patients between the ages of 21 and 69}
13.99BE	Other miscellaneous diagnostic and therapeutic procedures NEC {Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection}
17.71A	Peripheral nerve injection, unqualified {Local block(s) of somatic nerve(s)}
37.91A	Lingual frenotomy {Release of simple tongue tie, clipping}
51.92A	Injection of sclerosing agent or solution into vein {Varicose vein, single injection}
51.92B	Injection of sclerosing agent or solution into vein {Varicose vein, additional injection}
80.83B	Uterine biopsy {Endometrial biopsy}

81.8	Insertion of intra-uterine contraceptive device
93.91A	Arthrocentesis {Joint aspiration, injection, hip}
93.91B	Arthrocentesis {Joint aspiration, injection, other joints}
95.93	Injection/aspiration of therapeutic substance into bursa <Subacromial>
95.94A	Injection of therapeutic substance into other soft tissue {Injection with local anesthetic of myofascial trigger points combined with a spray and stretch technique}
95.96A	Aspiration of other soft tissue {Other bursae, tendon sheaths, ganglion of wrist or ankle, aspiration, injection}
98.01A	Tattooing or insertion into skin and subcutaneous tissue {Implantation of subdermal contraceptive implant}
98.03A	Other incision with drainage of skin and subcutaneous tissue {Incision and drainage of abscess or hematoma, subcutaneous or submucous}
98.04B	Incision with removal of foreign body of skin and subcutaneous tissue {Incision with removal of foreign body of skin and subcutaneous tissue without anesthesia}
98.11A	Debridement of wound or infected tissue {Non-functional area, up to 32 total square cms}
98.11D	Debridement of wound or infected tissue {Functional area, up to 32 total square cms}
98.12A	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Excisional biopsy, skin}
98.12B	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Excisional biopsy, skin of face}
98.12C	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal of sebaceous cyst}
98.12H	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Excision of soft tissue tumor(s) (subcutaneous)}

	full 30 minutes of operating time or major portion thereof for the first call when only one call is claimed}
98.12J	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal or excision, first lesion}
98.12K	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal by fulguration, first lesion}
98.12L	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {non-surgical treatment (cryotherapy, chemotherapy), warts or keratoses}
98.12M	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal of pigmented benign nevus, excluding face}
98.12N	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal of pigmented benign nevus of the face}
98.12Q	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal of any atypical or neoplastic lesion(s) - any method excluding cryotherapy for actinic keratoses} <<Multiple dysplastic or localized carcinomatous lesions of the skin>>
98.12R	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue {Removal of first plantar wart}
98.22A	Suture of skin and subcutaneous tissue of other sites {Laceration, face, up to 2.5 cms (1 unit) or body, up to 5 cms (1 unit)}
98.22B	Suture of skin and subcutaneous tissue of other sites {Laceration, face, over 2.5 cms (1 unit) and/or body, over 5 cms (1 unit)} <For each layer or unit, refer to Price List>
98.81A	Biopsy of skin and subcutaneous tissue {Biopsy, skin}
98.81B	Biopsy of skin and subcutaneous tissue {Punch biopsy}
98.96A	Removal of nail, nailbed or nailfold {Wedge excision}

98.99AA	Other operations on skin and subcutaneous tissue NEC {Acne surgery}<For incision and drainage and/or cryotherapy of cysts; and superficial peels for acne including liquid nitrogen and glycolic peels>
---------	---

## APPENDIX E: ANNUAL COMPLEXITY PAYMENTS TABLE

This appendix outlines Annual Complexity Payments, presented as a matrix using 2022-2023 billing data.

Chart A: Panel Payment Complexity Matrix – Female

COMPLEXITY CATEGORY	00 - 01	01 - 17	18 - 34	35 - 49	50 - 64	65 - 79	80 +
Healthy newborn	\$48.57	\$57.45					
Major acute	\$40.93	\$60.06	\$93.74	\$108.69	\$114.46	\$114.30	\$112.09
Major cancer	\$104.96	\$50.28	\$94.22	\$101.07	\$105.12	\$106.26	\$115.42
Major chronic	\$44.84	\$54.45	\$90.96	\$112.03	\$113.94	\$117.58	\$114.88
Major mental health		\$71.09	\$105.29	\$128.25	\$136.73	\$113.54	\$71.01
Major newborn	\$48.11	\$63.30					
Minor acute	\$59.36	\$45.63	\$59.86	\$65.27	\$66.50	\$69.34	\$75.97
Minor chronic	\$44.83	\$49.84	\$66.53	\$73.79	\$72.55	\$73.72	\$79.27
Moderate acute	\$32.87	\$57.09	\$86.36	\$98.00	\$100.45	\$105.93	\$112.72
Moderate chronic	\$43.83	\$54.26	\$84.04	\$93.82	\$97.70	\$97.28	\$104.78
Non-users		\$33.45	\$48.36	\$50.29	\$53.95	\$62.45	\$64.62
Obstetrics		\$60.95	\$73.87	\$81.59	\$109.03	\$109.37	

Other cancer		\$63.68	\$82.68	\$86.32	\$87.80	\$92.96	\$100.76
Other mental health	\$92.30	\$62.58	\$87.78	\$100.47	\$103.89	\$104.10	\$115.81
Palliative		\$75.19	\$75.19	\$75.19	\$95.47	\$89.51	\$62.39
Users without health conditions		\$36.14	\$46.45	\$48.23	\$48.61	\$52.03	\$54.58
Unassigned	\$66.77	\$47.27	\$70.50	\$80.41	\$85.98	\$92.28	\$98.72

Chart B: Panel Payment Complexity Matrix – Male

COMPLEXITY CATEGORY	00 - 01	01 - 17	18 - 34	35 - 49	50 - 64	65 - 79	80 +
Healthy newborn	\$50.62	\$60.81					
Major acute	\$49.31	\$54.28	\$66.92	\$84.42	\$91.32	\$98.68	\$109.75
Major cancer	\$92.00	\$48.89	\$61.85	\$81.13	\$87.92	\$94.48	\$111.56
Major chronic	\$44.45	\$51.22	\$67.49	\$82.62	\$93.99	\$102.95	\$112.99
Major mental health		\$52.88	\$83.63	\$99.27	\$110.45	\$99.13	\$80.99
Major newborn	\$48.67	\$66.93					
Minor acute	\$49.34	\$44.53	\$44.98	\$51.38	\$54.90	\$61.42	\$72.00

Minor chronic	\$60.25	\$48.40	\$50.64	\$59.84	\$63.14	\$69.11	\$79.15
Moderate acute	\$41.29	\$54.88	\$61.89	\$73.61	\$80.47	\$89.10	\$105.09
Moderate chronic	\$49.06	\$52.12	\$61.17	\$72.80	\$79.61	\$86.73	\$100.87
Non-users		\$33.66	\$35.92	\$39.59	\$44.64	\$58.29	\$75.17
Obstetrics							
Other cancer		\$62.40	\$60.77	\$63.79	\$70.34	\$77.94	\$92.49
Other mental health	\$75.28	\$52.07	\$70.80	\$84.13	\$92.89	\$100.25	\$103.28
Palliative		\$78.26	\$78.26	\$78.26	\$90.49	\$88.20	\$63.14
Users without health conditions		\$35.37	\$38.21	\$41.66	\$43.26	\$48.13	\$56.31
Unassigned	\$69.09	\$46.04	\$50.59	\$60.63	\$70.29	\$82.65	\$98.48