Cardiac Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 09 · Coronary bypass (CABG) · Valve surgery · Thoracic aorta · Updated November 2026
Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/cardiac-surgery

Pick the visit, tick what you did, bill the codes at the bottom. Ontario fees effective July 1, 2026.

Office consultation

A095A	Consultation Written referral from a physician or NP; written report back. Limit: 1 per patient per 2 years for the same diagnosis (GP17).	$113.15
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart and imaging review (GP19–GP20).	$194.65
A096A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	$75.20

- 50+ minutes face to face? A935A pays $194.65, $81.50 more than A095A. Time spent on procedures or reviewing images doesn't count (GP19–GP20).
- This is usually your decision-to-operate visit: it's paid on top of the surgery whenever the surgery happens (SP2).
- A second consult for the same diagnosis within 2 years is paid as a specific assessment, unless it's a repeat consult or an in-patient/ED consult 12–24 months later (GP17).
- Pre-op work-up done, admitting for elective surgery? The hospital admission assessment isn't payable unless it is that decision-to-operate visit (SP2, GP40).

Office follow-up

A094A	Follow-up or post-op visit History of the problem, the exam needed, advice. Partial assessment.	$30.35
A093A	Full work-up of one problem Full history of the complaint and detailed exam of the affected system. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	$55.70

- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Routine follow-ups are A094A. A093A is limited to 1 a year per patient (2 for a clearly different diagnosis) (GP23).
- Phoned or e-consulted another physician about this patient? K730A ($37.05) or K738A ($16.45) is paid on top of today's visit (A42, A48). Sending them home with home care: K070A ($34.75) (A58).
- E078A (chronic disease premium) isn't payable to cardiac surgery (09): GP25 lists the specialties that can bill it, and 09 isn't one.

Coronary bypass (CABG)

R742A	One graft Coronary artery repair, one (Q7).	$981.85
R743A	Two or more grafts Coronary artery repair, two. Each graft after the second: tick E654A below (Q7).	$1,401.25

- On pump: add E650A ($400.00). Off pump: E645A ($371.00) instead; the assistant then bills E645B (24 units) and the anaesthetist E645C (40 units), not R742A/R743A B or C (Q2, Q7).
- Arterial conduit (internal mammary, radial or epigastric): E652A +$187.85. Harvesting the conduit itself is included and never billed (Q1, Q7).
- Redo more than a month after the first operation: E671A +$543.60 after a sternotomy, E670A +$224.70 after a thoracotomy (Q3).
- Valve too? Use the Valve surgery tile: the bigger procedure is paid in full and the other at 85% (SP2 §3).
- E516A (endocarditis) and E676A (BMI over 40) aren't payable with R742A or R743A (Q1, SP6). A second assistant needs no prior approval for R742A, R743A or E645A (GP90).

Valve surgery

R732A	Aortic valve replacement, open Patch aortoplasty E647A and annulus enlargement E656A add on (Q10).	$1,548.25
R739A	Aortic valve replacement, percutaneous (TAVI) Includes access, imaging guidance, balloon valvuloplasty and deployment; no separate image fees (Q10).	$949.20
R735A	Mitral valve replacement Q10.	$1,315.65
R773A	Mitral repair, simple Includes annuloplasty (Q10).	$1,648.25
R774A	Mitral repair, complex Includes annuloplasty and repair of both the anterior and posterior leaflets (Q10).	$2,058.20
R863A	Modified Bentall Aortic valve + ascending aorta replaced, coronaries reimplanted (Q10).	$2,153.40
R876A	Valve-sparing aortic root replacement or remodelling Q10.	$2,230.75

- Two valves: the major valve in full plus 85% for each other valve (Q10). Valve plus CABG or Maze works the same way (SP2 §3).
- Active infective endocarditis that complicates the operation: E516A +25%, once per surgical event. Needs pre-op tests and operative findings; not for TAVI, and not if the IE is incidental or resolved (Q1).
- TAVI: E650A is paid only when bypass was medically necessary (hybrid procedure, complication or patient indication) and the op note says so (Q10).
- Mitral repair already includes annuloplasty: don't add R734A. Complex repair (both leaflets) pays $409.95 more than simple (Q10).
- Closed the left atrial appendage too: E521A +$200.00; not with a Maze (R709A), which already includes it (Q5–Q6).

Thoracic aorta

R799A	Ascending aorta, repair or graft One surgeon (Q14).	$1,473.15
R800A	Aortic arch One surgeon (Q14).	$1,840.35
R801A	Descending aorta With or without temporary shunt (Q14).	$1,260.30
R803A	Thoraco-abdominal aneurysm A second anaesthesiologist may also claim R803C (Q14).	$3,261.85
R890A	Ascending aorta, two surgeons: you're the first Second surgeon bills R891A ($1,104.85), no assistant or anaesthesia units (Q14).	$1,104.85
R892A	Aortic arch, two surgeons: you're the first Second surgeon bills R893A ($1,380.25) (Q14).	$1,380.25

- Two surgeons together earn more: an ascending repair is $1,104.85 each ($2,209.70) against $1,473.15 for one surgeon. Codes: R890A/R891A, R892A/R893A arch, R894A/R895A descending, R898A/R899A thoraco-abdominal (Q14).
- Rupture: E667A +$266.60 on the thoracic codes; E627A +$619.25 on thoraco-abdominal R803A (Q14–Q15).
- Aortic root with the valve is the Bentall R863A or valve-sparing R876A on the Valve tile (Q10).
- Emergency (dissection, rupture): bill the ED consult with its premiums from the Called to ED tile, plus the operation; started 17:00–07:00 or on a weekend or holiday, add E409A or E410A (SP2 §2, GP104).
- BMI over 40: E676A +25% is payable with R800A and R803A only, of these codes (SP6).

Arrhythmia, septal & pericardial

R709A	Left atrial Maze or ablation Includes all left atrial lines, pulmonary veins and the left atrial appendage (Q5).	$778.65
R706A	Right and left atrial ablation Everything in R709A plus right atrial lines (Q5).	$1,245.85
R740A	Left atrial appendage occlusion, sole procedure By suture or device. With another procedure use E521A instead (Q6).	$400.00
R715A	ASD closure, secundum Open (Q7).	$828.65
R718A	VSD closure Once, however many defects one patch closes (Q7).	$948.75
R714A	Cardiac tumour removed Cardiotomy with removal of tumour (Q5).	$576.40
R749A	Pericardiectomy, both sides or sternal split One side open: R748A ($635.45) (Q5).	$1,097.90
R707A	Surgical drainage for tamponade Open or VATS. Only with tamponade and clinical instability (Q5).	$600.00

- R706A includes everything R709A does: bill one, not both (Q5).
- Left atrial appendage alone is R740A ($400.00); during another operation it's the add-on E521A ($200.00), and not with R709A (Q6).
- R707A isn't paid for an effusion without tamponade and instability, or with pericardiocentesis or pericardiectomy (Q5). Needle drainage at the bedside: Z401A ($131.70).
- Done with a valve or CABG under the same anaesthetic? Pick that tile and tick the Maze there: the smaller procedure is paid at 85% (SP2 §3).

VAD, ECMO & transplant

R704A	Implantable VAD Q4.	$2,163.35
R701A	Short-term VAD, one ventricle Paracorporeal device in for under 14 days. Both ventricles: R702A ($1,334.80) (Q4).	$721.60
R703A	Paracorporeal VAD, 14+ days Claim only once the device has been in 14 days (Q4).	$1,443.05
R705A	VAD removed (in 14+ days) Includes vessel repair. Device in under 14 days: Z744A ($123.05). Only one of them per day (Q4).	$508.55
Z788A	ECMO started Includes cannulation, decannulation and vessel repair, any method. Not a VAD code (Q2, Q4).	$400.00
R870A	Heart transplant Heart-lung: R874A ($2,565.30) (Q8).	$1,659.50
R872A	Donor cardiectomy Bill on the donor's health number (Q8, SP8).	$527.80

- Under 14 days on a paracorporeal device: R701A or R702A. 14+ days: R703A, and removal R705A, submitted only once the device has been in 14 days (Q4).
- RVAD to support an LVAD: R701A is payable with R703A or R704A whatever the duration. Replaced a device: bill both removal and insertion (Q4).
- Removing a VAD at transplant is payable (R705A or Z744A) (Q4).
- Recipient's claims go on the recipient's health number; donor claims on the donor's, or the Ontario recipient's if the donor is from out of province (SP8).
- Graft sewn to a vessel other than the ascending aorta for bypass or VAD cannulation: E682A +$423.85 (Q2).

Called to ED or ward

A095A	Consultation Requested by the ED or ward physician. Written report.	$113.15
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	$194.65
A096A	Repeat consultation Same problem, new request, after another physician's care in between.	$75.20
A093A	Full work-up, your own patient Specific assessment.	$55.70
A094A	Brief assessment Partial assessment.	$30.35

- Called in non-electively: bill A-prefix codes plus the special visit premiums, not C-codes (GP43, GP65).
- The premiums shown are the ED table (I). For a ward in-patient (table III) or out-patient clinic (table II) the amounts are the same; bill that table's codes (GP71–GP72).
- Weekday daytime emergency surgery: consult + special visit premium + operation. Evenings, nights, weekends: add E409A or E410A to the operation (SP2 §2).
- Admitting the patient as MRP? E082A adds 30% to this consult, once per admission (GP42).
- Bedside procedure now (pericardiocentesis, balloon pump, chest tube)? Tick it below; it's paid on top.

In-patient consult

C095A	Consultation Requested by the attending physician, routine (not a called-in visit).	$113.15
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	$194.65
C096A	Repeat consultation	$75.20
C093A	Full work-up Specific assessment.	$55.70
C094A	Re-assessment Specific re-assessment. 2 per 12 months except admissions (GP23).	$32.70
C098A	Concurrent care You keep following the patient while another physician is the MRP. Limit: 4 in week 1, then 2 a week (GP48).	$31.00

- Called in urgently instead? Use the ED or ward tile for A-codes and premiums (GP43).
- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2, GP40).
- A surgeon brought into the case on consultation who then operates or assists may also claim the consult, justified on an IC basis (SP3 §8).
- Seen in ICU or CCU: C101A adds $9.10 per patient, unless critical care team fees are claimed (GP103).

Hospital rounds

C122A	Day after admission, you're the MRP Once per admission (GP44).	$71.80
C123A	Second day after admission, you're the MRP Once per admission (GP44).	$71.80
C142A	First visit after transfer out of ICU, you're the MRP Patient was getting critical, ventilatory or comprehensive care, not just monitoring, and you didn't give that care. One of C122A or C142A per admission (GP46).	$71.80
C143A	Second visit after transfer out of ICU, you're the MRP Same conditions. One of C123A or C143A per admission (GP46).	$71.80
C092A	Routine daily visit 1 a day in weeks 1–5; then C097A (3 a week) and C099A (6 a month) (GP43).	$31.00
C124A	Discharge day, you're the MRP Stay over 48 hours; discharge summary within 48 hours (GP45).	$71.80
C126A	Discharge day, complex patient Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes (A13).	$95.10
C121A	Extra visit for an acute intercurrent illness After week 5, when the weekly or monthly limit is used up; the limits don't apply to it (GP43).	$40.05

- As MRP, C122A and C123A pay $71.80 instead of $31.00 for the first two days after admission (GP44). Most post-op cardiac patients come to the ward from the ICU: then C142A and C143A replace them (GP46).
- E083A adds 30% to your MRP visits. The E084A weekend premium isn't open to cardiac surgery (09) (GP47).
- Visit limits run from the admission date if you admitted the patient, or from the referral date if they were referred to you in hospital (SP2).
- Surgery cancelled before induction counts as a subsequent visit; after induction with you scrubbed, bill E006A (SP7 §27).
- Long-term care patients: consults W095A ($113.15) and W096A ($75.20) (A82).

Also bill, if it's true

G521A	Life-threatening critical care, up to 15 min Vital organ failure with imminent risk of death. Time at the bedside or on the floor, no other patients meanwhile; start and stop times charted (J26–J27).	$125.10
G521A + G523A	Life-threatening critical care, 16–30 min First and second quarter hour (J26).	$189.60
G522A	Critical care, each further 15 min after 30 Tick with 16–30 min. 4th and later physicians tick G391A instead (J26).	$42.50
G395A	Other critical care (resuscitation), first 15 min Threat to life or limb that, without your resuscitation, would likely need life-threatening critical care or cost the limb. Not with G521A–G523A the same day (J28).	$64.70
G391A	Critical care, each further 15 min after G395A, or 4th+ physician Tick with G395A for each quarter hour after the first. 4th and later physicians on a life-threatening case bill G391A per 15 min instead of G521A–G523A (J26, J28).	$34.35
K036A	Northern Health Travel Grant form Your part of the form for a patient travelling from Northern Ontario. Paid to the referring physician and the specialist (A60).	$10.25
K070A	Home care referral form You're the MRP sending the patient to Ontario Health atHome (wound care, IV). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	$34.75
K730A	Phoned another physician for advice 10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test, or mainly to discuss results. Start and stop times charted. 1 a day. Paid on top of the visit (A42–A43).	$37.05
K738A	Sent an e-consult to another physician Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months. Paid on top of the visit (A48–A49).	$16.45
K121A	In-patient case conference, per unit Pre-scheduled, with the MRP and 2+ others, 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months. Your visit outside the conference is still paid (A31–A33).	$37.05
C101A	Patient seen in ICU or CCU Per patient. Not with critical care, ventilatory or comprehensive care team fees (GP103).	$9.10
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for day surgery; not if the hospital pays you for in-patient work (GP42).	+30%
E083A	You're the MRP +30% on MRP subsequent visits. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).	+30%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the consult (GP103–GP104).	+50%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the consult (GP103–GP104).	+75%
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of the procedural fees; shown here on the main operation and any procedure ticked below (GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of the procedural fees; shown here on the main operation and any procedure ticked below (GP104).	+75%
E420A	Trauma patient with ISS over 15 (over 12 under age 16) +50% on the day of the trauma or within 24 h. ISS in the chart; same claim. Not on special visit or after-hours premiums (GP109).	+50%
A095A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2).	$113.15
A095A	Consult that led to this emergency operation Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).	$113.15

A093A	Assessed your own patient before the operation Specific assessment (SP2 §2).	$55.70
E654A	Each graft after the second Coronary artery repair, each additional (Q7).	$188.85
E650A	Pump run (cardiopulmonary bypass) Cannulation, decannulation and supervision of the pump. The anaesthetist bills E650C, 28 units, instead of the procedure's units (Q2).	$400.00
E645A	Done off pump To R742A or R743A. Assistant E645B 24 units, anaesthetist E645C 40 units (Q7).	$371.00
E652A	Internal mammary, epigastric or radial artery graft To R742A or R743A (Q7).	$187.85
E651A	Coronary endarterectomy To R742A or R743A (Q7).	$202.05
E646A	Vein patch angioplasty of a coronary artery Q7.	$187.80
E671A	Redo after a previous sternotomy Open heart re-operation more than one month after the first (Q3).	$543.60
E670A	Redo after a previous thoracotomy More than one month after the first operation (Q3).	$224.70
E682A	Graft to a major vessel (not the ascending aorta) for bypass or VAD cannulation To E650A, R701A–R704A or Z743A (Q2).	$423.85
E521A	Also closed the left atrial appendage Suture or device, with another procedure. Not the same day as R709A (Q6).	$200.00
R709A	Also a left atrial Maze or ablation (85%) R709A at 85% under the same anaesthetic ($778.65 full). Includes the appendage, so no E521A (Q5–Q6, SP2 §3).	$661.85
R706A	Also a right and left atrial ablation (85%) R706A at 85% ($1,245.85 full). No E521A (Q5, SP2 §3).	$1,058.97
E516A	Active infective endocarditis complicated the operation +25% of the procedural fee, once per surgical event. Shown on the main operation. Pre-op diagnosis and operative findings in the chart (Q1).	+25%
E647A	Patch aortoplasty (pericardium or graft) To R732A and/or aortic annuloplasty (Q10).	$264.70
E656A	Aortic annulus enlarged To R732A and/or patch aortoplasty (Q10).	$288.85
R732A	Also replaced the aortic valve (85%) R732A at 85% ($1,548.25 full): the other valve is the major one (Q10).	$1,316.01
R735A	Also replaced the mitral valve (85%) R735A at 85% ($1,315.65 full) (Q10).	$1,118.30
R727A	Also a tricuspid annuloplasty (85%) R727A at 85% ($678.80 full) (Q10, SP2 §3).	$576.98
R728A	Also replaced the tricuspid valve (85%) R728A at 85% ($777.40 full) (Q10).	$660.79
R742A	Also bypassed one coronary artery (85%) R742A at 85% ($981.85 full) (SP2 §3).	$834.57
R743A	Also bypassed two or more coronary arteries (85%) R743A at 85% ($1,401.25 full). Grafts after the second: E654A each (Q7, SP2 §3).	$1,191.06
E667A	Ruptured Thoracic aortic aneurysm (Q14).	$266.60
E627A	Ruptured To R803A or R898A (Q15).	$619.25

E676A	BMI over 40, general anaesthetic +25%, once per patient. BMI charted. Only with the codes listed on SP6: R800A and R803A here (SP6–SP7).	+25%
R701A	Also an RVAD to support the LVAD (85%) R701A with R703A or R704A, any duration (Q4); second procedure at 85% ($721.60 full) (SP2 §3).	$613.36
R705A	Removed the VAD at transplant (85%) R705A for a device in 14+ days; under 14 days Z744A. Payable with the transplant (Q4); 85% of $508.55 (SP2 §3).	$432.27

Did a bedside or ICU procedure?

Z780A	Intra-aortic balloon pump, percutaneous Includes cannulation, artery repair, daily care and supervision. Open: Z743A ($307.80) (Q2).	$219.80
Z781A	Balloon pump removed, percutaneous Open removal Z744A ($123.05), includes artery repair; no R815A with it (Q3).	$39.00
Z782A	Balloon pump repositioned, percutaneous Not within 24 h of insertion. Open: Z751A ($127.95) (Q3).	$82.55
Z788A	ECMO started Includes cannulation and decannulation (Q2).	$400.00
Z438A	Swan-Ganz catheter During an operation with anaesthesia units it's included in those units (J7).	$162.50
G268A	Arterial line Not with a temporary pacing wire Z443A (J7). In the OR it's part of the anaesthetist's basic units (Q2).	$31.25
G269A	Central line Not with a Swan-Ganz or right heart catheterization (J7).	$31.25
Z443A	Temporary transvenous pacing wire Repositioned later: Z431A ($64.25) (J13).	$154.10
Z437A	Cardioversion Electrical and/or chemical. Max 3 sessions per patient per day (J9).	$92.45
Z401A	Pericardiocentesis Sclerosing agent injected: Z414A ($23.10) (Q5).	$131.70
Z341A	Chest tube P14.	$76.80
Z363A	Chest tube removed Not the same day as Z341A (P14).	$20.00
Z332A	Thoracentesis Diagnostic or therapeutic (P14).	$104.40
M134A	Re-opened the chest for post-op bleeding Thoracotomy for post-operative haemorrhage or empyema (P14). A later operation for a complication is paid in full (SP2 §4).	$390.65
M112A	Sternal debridement and rewiring As sole procedure (P12).	$500.00
R765A	Open cardiac massage Q3.	$231.30
Z080A	Wound debridement into fat, one 10+ min, by you, time charted. Into tendon or bone Z084A ($65.75). Not after your own surgery unless a complication needs more than usual post-op care (M10).	$21.90
Z444A	Permanent pacemaker, endocardial lead and pack Includes a temporary lead at the same procedure. Dual chamber R752A ($454.55) (Q3).	$323.75
Z428A	Pacemaker lead extraction With or without laser (Q4).	$598.50
E628A	Each additional lead extracted Q4.	$194.50
R761A	ICD, transvenous By thoracotomy R753A ($720.30). Inducing VT at implant: G259A at 85% (Q4).	$587.35

Can I bill these together?

Code	With	Together?	Why
G521A,G523A,G522A	G395A	No	G395A isn't paid with G521A, G522A or G523A the same day (J28).
G391A	G521A, G523A, G522A	No	G391A is either the 4th and later physicians' fee in place of G521A–G523A (J26), or the time after G395A, which isn't paid with G521A–G523A the same day (J28).
G521A,G523A,G522A	G211A, Z437A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters, drugs given, defibrillation and cardioversion are included in life-threatening critical care (J26).
G395A,G391A	G211A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters and drugs given are included in other critical care (J28).
G521A,G395A	A095A, A935A, A096A, A093A, A094A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and its time can't count twice (J27, J28).
A095A,A935A,A096A,C095A,C935A,C096A	R742A, R743A, R732A, R739A, R735A, R773A, R774A, R863A, R876A, R799A, R800A, R801A, R803A, R709A, R706A, R740A, R715A, R718A, R714A, R749A, R707A, R704A, R701A, R703A, R870A	Yes	The consult where you decide to operate is the major pre-operative visit: never included in the surgical fee, whenever the surgery happens (SP2, GP4).
A093A,A094A,C093A,C094A	R742A, R743A, R732A, R739A, R735A, R773A, R774A, R863A, R876A, R799A, R800A, R801A, R803A, R709A, R706A, R715A, R749A, R704A	Sometimes	Only when this is the visit where you decided to operate. A hospital admission assessment that isn't that visit isn't paid (SP2).
A935A	A095A	No	A935A is the consultation itself, billed instead of A095A when you spend 50+ minutes face to face (GP19–GP20).
E654A,E652A,E651A,E646A,E645A	R742A, R743A	Yes	Coronary bypass add-ons, paid on top of R742A or R743A (Q7).
E654A	R742A	No	E654A is each graft after the second: bill R743A for two grafts, then E654A (Q7).
E516A	R742A, R743A, R739A	No	E516A is only payable with the valve and root codes listed on Q1; CABG and TAVI aren't on the list (Q1).
E516A	R732A, R735A, R773A, R774A, R863A, R876A, R727A, R728A	Yes	+25% when active infective endocarditis, confirmed before and during surgery, complicates the operation; once per surgical event (Q1).
E650A	R739A	Sometimes	Only when cardiopulmonary bypass was medically necessary (hybrid procedure, complication or patient indication), confirmed in the op note (Q10).
E650A	E682A	Yes	E682A is listed to E650A (Q2).
E647A,E656A	R732A	Yes	Patch aortoplasty and annulus enlargement add to R732A (Q10).
R734A	R773A, R774A	No	Mitral reconstruction already includes annuloplasty (Q10).
E521A	R709A, R706A	No	E521A isn't paid the same day as R709A, and R706A includes all of R709A (Q5–Q6).
R740A	R742A, R743A, R732A, R735A, R773A, R774A, R863A, R876A	No	R740A is for appendage occlusion as the sole procedure; with another procedure bill E521A (Q6).
R709A	R706A	No	R706A includes all the required elements of R709A (Q5).
R707A	Z401A, R748A, R749A	No	R707A isn't paid with pericardiocentesis or pericardiectomy (Q5).

Code	With	Together?	Why
R705A	Z744A	No	Only one of Z744A or R705A per patient per day for VAD removal (Q4).
R705A,Z744A	R870A	Yes	Removing the VAD is payable with the heart transplant (Q4).
R701A	R703A, R704A	Sometimes	Only for a right ventricular assist device supporting a left one; then any duration (Q4).
Z744A	R815A	No	R815A isn't claimed with Z744A (Q3).
Z782A	Z780A	Sometimes	No claim for repositioning within 24 hours of the original insertion (Q3).
G269A	Z438A, Z439A	No	G269A isn't billed with right heart catheterization or a Swan-Ganz insertion (J7).
G268A	Z443A	No	G268A isn't paid with a temporary transvenous pacing lead Z443A (J7).
Z363A	Z341A	No	Chest tube removal isn't paid the same day as its insertion (P14).
Z444A	Z443A	No	Z444A includes a temporary transvenous lead at the same procedure by the same surgeon (Q3).
E628A	Z428A	Yes	Each additional lead extraction adds to Z428A (Q4).
E676A	R742A, R743A, R732A, R735A, R799A, R801A	No	E676A is only payable with the procedures listed on SP6; these aren't (SP6).
E676A	R800A, R803A	Yes	R800A and R803A are on the SP6 list: +25% for BMI over 40 under general anaesthetic, BMI charted (SP6–SP7).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).
E420A	E409A, E410A	Yes	E420A isn't applied to the after-hours premium, but the after-hours premium is still payable (GP109).
E078A	A093A, A094A	No	E078A is only paid to the specialties listed in GP25; Cardiac Surgery (09) isn't one of them (GP25).
K036A,K070A,K730A, K738A	A095A, A935A, A096A, A093A, A094A, C124A, C126A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K070A with the assessment (A58); K730A and K738A with visits the same day (A42, A48).
C122A	C124A, C126A, C092A	No	One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
E083A	C098A	No	E083A is only for the MRP's own subsequent visits (GP47).
E084A	C092A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Cardiac Surgery isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026): Cardiac Surgery A81–A82, Cardiovascular Surgical Procedures Q1–Q11, the Surgical Preamble and the General Preamble; pages in brackets. Totals are your fee only (suffix A): the surgical assistant bills the Asst units × $12.91 and the anaesthetist the Anae units × $15.96, plus time units, with suffix B or C (GP85, GP92); with a pump the anaesthetist uses E650C, off pump E645C. A second procedure under the same anaesthetic is paid at 85% (SP2 §3): options marked 85% show that amount; other ticked procedures show their full fee. Percentage premiums (E409A, E410A, E420A, E516A, E676A) are shown on the main operation and ticked bedside procedures only; OHIP applies them to every eligible procedural fee. Age premiums for patients under 16 on consults and surgery (+10% to +30%) are added by OHIP on the remittance (GP64).

Fees are the Ontario Schedule of Benefits amounts and may change. Billing codes, rules and rejections for every code: verismo-apex.com/resources/billing.