

Cardiology OHIP Billing Cheat Sheet 2026

OHIP specialty 60 · Reading tests only · In-patient or CCU consult · Counselling or interview · Updated October 2026

Interactive version: <https://verismo-apex.com/resources/ohip-billing-cheatsheet/cardiology>

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

Office consultation

A605A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same problem: 1 per 2 years. Unrelated problem: 1 per 12 months.	\$188.45
A600A	Comprehensive consultation, 75+ minutes face to face All the elements of a consultation plus at least 75 minutes of direct contact. Record start and stop times or it is paid as a lesser fee. Time on separately billed tests (ECG, echo) and chart or imaging review does not count (A79).	\$342.25
A675A	Limited consultation A real referral, but a narrow question that took much less time than a full consult (GP19).	\$105.25
A606A	Repeat consultation Same problem you consulted on before, the patient was cared for by another doctor in between, and a new written referral came in (GP19).	\$105.25

- Spent 75+ minutes face to face? A600A pays \$342.25, \$153.80 more than A605A. Chart start and stop times; the ECG or echo you bill separately doesn't count toward the 75 (A79).
- Same patient, same problem: only 1 consultation per 2 consecutive 12-month periods. A 2nd within the first 12 months is paid as an assessment. Exception: a 2nd consult 12 to 24 months later in hospital or the ED (GP17).
- The ECG, Holter, stress test or echo you read the same day is paid on top of the consult: tick it under Did a procedure or test? (J3).
- No written referral on file, or one requested after the visit, means it is paid as an assessment (GP16).

Office follow-up

A604A	Re-assessment Full history of the problem and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	\$72.65
A601A	Complex re-assessment, letter to the family doctor Complex, obscure or serious condition. Send your findings in writing to the primary care physician or it is paid as a lesser fee (GP24). Limit: 4 per 12 months (shared with A603A).	\$84.10
A603A	Full assessment of a new problem, no referral Full history of the presenting complaint and a detailed exam of the affected systems (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$96.70
A608A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit.	\$49.80

- Heart failure patient? Tick E088A: +50% on A603A, A604A, A601A or A608A in the office or a hospital clinic, with diagnostic code 428 on the claim. A601A + E088A = \$126.15 (A79–A80).
- Order to reach for: A601A (\$84.10) when the problem is complex and you send a letter, then A604A (\$72.65), then A608A (\$49.80).
- A603A and A601A share a limit of 4 per patient per 12 months; A604A is 2 per 12 months. Extras are paid as a lesser fee (GP23–24).
- E088A is also payable on phone and video follow-ups (A74), but not in the ED, in hospital or in LTC (A79).
- E078A (chronic disease premium) isn't payable to cardiology (60): GP25 limits it to geriatrics, endocrinology, neurology, paediatrics, pathology, physical medicine, radiation oncology, medical oncology, infectious disease, respirology, rheumatology, haematology and clinical immunology, so OHIP won't pay it. For heart failure, tick E088A instead: +50% with dx 428 (A79–A80).

Reading tests only

- Reading a test done on someone else's equipment (hospital, ICHSC)? Bill the professional component only. The technical part goes to whoever owns the machine (GP11).
- ECG, stress tests and echo aren't paid for routine pre-op screening of low-risk patients or surgery (J14, J15, J20).
- Holter over 36 hours: use the code for the full duration, not multiples of shorter ones. 14+ day recordings: once per 30 days (J17).
- Echo is paid only at an accredited facility, by a Level II/III-trained reader, for a CorHealth-standard indication (J20).
- A stress test includes the resting ECGs before and after: don't add G313A (J15).

Called to the ED

A605A	Consultation ED doctor's request on the chart; report back to them.	\$188.45
A600A	Comprehensive consultation, 75+ minutes face to face Record start and stop times.	\$342.25
A603A	Full assessment, no consult request e.g. your own patient sent in to you.	\$96.70
A604A	Re-assessment Your own patient you assessed recently.	\$72.65
A608A	Quick look or advice	\$49.80
• If you admit the patient, this ED consult is the admission assessment: don't bill a second one. As MRP, add E082A (+30%) to it (GP40, GP42). • Not on ED duty when called? Bill your A-code plus the ED special visit premiums (K960A travel, K990A–K999A person seen). Never with H-codes (GP65, GP70). • No E088A heart failure premium in the ED (A79). The ECG you read is billed on top. • Stayed with an unstable patient? Detention K001A (\$21.10 per 15 min) starts after 60 minutes of a consult or 120 of A600A (GP30–31). • Shock or another vital organ failure? Life-threatening critical care: G521A \$125.10 first 15 min, G523A \$64.50 the second, G522A \$42.50 each 15 min after. Only time at the bedside or on the patient's floor, start and stop times charted; cardioversion, lines and intubation are included (J26–J27).		

In-patient or CCU consult

C605A	Consultation Requested by the attending doctor; written report on the chart.	\$188.45
C600A	Comprehensive consultation, 75+ minutes face to face Same conditions as A600A: start and stop times charted.	\$342.25
C675A	Limited consultation Narrow question, much less time than a full consult.	\$105.25
C606A	Repeat consultation Same problem after another doctor's care, new request.	\$105.25
C603A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	\$96.70
A605A	Called urgently to see another doctor's in-patient Emergency call to the ward: bill A-prefix codes and the in-patient special visit premiums (GP43).	\$188.45
• Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission. Not for transfers within the hospital (GP42). • Seen your patient for the same illness in the last 90 days? The admission assessment is a re-assessment (C604A, \$72.65), not C603A (GP40). • Patient in the CCU or ICU: add C101A (\$9.10) per patient, unless critical care team fees are billed (GP103). • Cardioversion (Z437A) and the ECG or echo you read are billed on top (J9). • Physician in charge of a critically ill CCU patient (not just monitoring)? Critical care per diem G400A \$223.10 day 1, G401A \$146.45 days 2–30, G402A \$58.60 from day 31. No other critical care codes or C101A that day (J30–J31, GP103).		

Hospital rounds

C122A	MRP visit, day after admission Once per admission (GP44).	\$71.80
C123A	MRP visit, 2nd day after admission Once per admission.	\$71.80
C142A	MRP, 1st visit after transfer out of ICU/CCU Patient was getting critical, ventilatory or comprehensive care, not just monitoring. Replaces C122A (GP46).	\$71.80
C602A	Subsequent visit Weeks 1–5: 1 a day. Weeks 6–13: C607A, 3 a week. After week 13: C609A, 6 a month (GP43).	\$40.05
C124A	MRP, day of discharge Discharge summary within 48 h (reason, procedures, diagnosis, meds). Not if stay under 48 h (GP45).	\$71.80
C126A	MRP, discharge of a complex patient Stay 7+ days, 3+ diagnoses that lengthened it, 45+ minutes of your time. Instead of C124A (A13).	\$95.10
• As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays. One per patient per day (GP47). • C122A + E083A = \$93.34 versus a plain C602A at \$40.05: claim the MRP codes on days 1, 2 and discharge. • Complex discharge (7+ day stay, 3+ diagnoses, 45+ minutes): C126A pays \$95.10, \$23.30 more than C124A (A13). • Following while another doctor is MRP? That's concurrent care C608A (\$40.05): 4 the first week, then 2 a week, no E083A (GP48).		

Counselling or interview

K013A	Counselling or education Booked visit only for advice and education (risk factors, new diagnosis, device). First 3 units per patient per 12 months.	\$80.00
K033A	Counselling, after the first 3 units this year	\$56.30
K002A	Interview with relatives or substitute decision-maker Separately booked, about the patient's care, not only for consent.	\$80.00
K015A	Counselling relatives of a dying patient Billed on the ill patient's number.	\$80.00

- Counselling is open to every specialty (GP9). 20 minutes of K013A pays \$80, more than A604A (\$72.65).
- With counselling, no consult or assessment the same day. Blood draws, K002A, the MTO report K035A, the travel grant form K036A and your own phone call for advice K730A are allowed; case conferences and the home care form are not (GP58).
- Book it as its own appointment and chart start/stop times: 20 min = 1 unit, 46 = 2, 76 = 3 (GP54, GP58).

Advice to another doctor

K731A	Phone call with the referring doctor or NP, 10+ minutes Patient-related discussion; chart start/stop times, reason and your advice (A43–A44). Limit: 1 per patient per day.	\$47.75
K739A	E-consultation through a secure server Opinion sent within 30 days (A48). Limit: 6 per patient per 12 months, 400 a year.	\$20.50
K733A	Call arranged by CitiCall Ontario Patient and referrer in Ontario (A45).	\$47.75
K735A	Phone consult while you're on ED duty Use instead of K731A when on shift in an ED or urgent care clinic.	\$47.75

- Put the referring doctor's or NP's billing number on the claim or it isn't paid.
- Not paid if you see the patient the same day or the next day: bill the visit instead (A43, A49).
- Not paid when the call is to arrange a transfer, a visit or a test, or mainly to discuss ECG or echo results.

Phone or video

A605A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	\$188.45
A604A + K300A	Video re-assessment Full fee.	\$72.65
A604A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	\$72.65
A601A + K301A	Phone complex re-assessment, letter to family doctor 85% of \$84.10.	\$84.10
A608A + K301A	Phone quick follow-up 85% of \$49.80.	\$49.80

- Heart failure follow-up by phone or video still gets E088A (+50% of what's paid for the virtual visit, A74). Tick E088A and use diagnostic code 428. Not on a video consultation (A79).
- Video pays 100%, phone 85%. Patient must have seen you in person in the last 24 months, or had a video consult with you (A66).
- The patient (or a needed follow-up) must start it. Calls only to give normal results aren't billable. Record phone or video in the chart.

Also bill, if it's true

E088A	Patient has established heart failure +50%. Office or hospital clinic, not ED or in-patient. Diagnostic code 428 on the claim (A79–A80).	+50%
E082A	I'm admitting as MRP: admission premium +30% of the admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	I'm the MRP, weekday +30% on subsequent visits and C121A–C143A. One of E083A/E084A per patient per day (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A (GP47).	+45%
C101A	Patient is in the CCU or ICU Per patient seen. Not with critical care or ventilatory team fees (GP103).	\$9.10
K001A	Stayed with the patient: detention, per 15 min Active treatment or monitoring to the exclusion of other work, after 60 min of a consult (120 for A600A, 40 for a re-assessment). Not for waiting (GP29–31).	\$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	\$80.00
A605A	Also saw the patient: consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$188.45
A603A	Also saw the patient: full assessment of a new problem, no referral Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$96.70
A604A	Also saw the patient: re-assessment Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$72.65
A601A	Also saw the patient: complex re-assessment, letter to the family doctor Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$84.10
A608A	Also saw the patient: quick look or advice Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$49.80
A600A	Also saw the patient: comprehensive consultation, 75+ minutes face to face Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$342.25
A675A	Also saw the patient: limited consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$105.25
A606A	Also saw the patient: repeat consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$105.25
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 bill G391A \$34.35 per 15 min instead (J26).	\$42.50
G489A	Blood draw	\$3.54
K035A	Reported a medical condition to the MTO (driving) e.g. syncope, arrhythmia, ICD shock. More than one a year for the patient: submit with the manual review indicator. Paid on top of the visit (A59).	\$36.25
K036A	Northern health travel grant form Paid to the specialist as well as the referring doctor (A60).	\$10.25
K730A	Phoned another doctor for advice, 10+ min e.g. cardiac surgery or EP. You keep caring for the patient. Not to arrange a referral, transfer, visit or test, or mainly to discuss results. Max 1 per patient per day. Paid on top of the visit (A42–A43).	\$37.05
K738A	Sent an e-consult to another doctor Through a secure e-consult service; paid once the other doctor answers within 30 days. Max 1 a day and 6 per patient per 12 months. Paid on top of the visit (A48–A49).	\$16.45

K070A	Filled in a home care referral form You're the most responsible physician and give ongoing care. Once per Ontario Health atHome admission; not if they're already on home care. Paid on top of the visit (A58–A59).	\$34.75
K121A	Hospital case conference, per unit Pre-scheduled; the MRP plus 2 other physicians or regulated professionals; 10+ min about this patient. Units: 10, 16, 26, 36 min... Max 4 per patient per 12 months. Today's visit is still paid if it wasn't during the conference (A31–A33).	\$37.05

Did a procedure or test?

G310A + G313A	ECG done in your office, with your reading Needs symptoms, signs or a guideline indication (J14).	\$12.25
G313A	Reading an ECG done elsewhere Professional component, written interpretation.	\$4.55
G315A + G319A	Treadmill stress test in your office You must be in attendance throughout. Includes resting ECGs and the pre-test assessment (J15).	\$112.60
G319A	Treadmill stress test, supervising and reading only Hospital or other owner bills the technical part.	\$62.05
G112A	Dipyridamole thallium stress, professional	\$74.25
G651A + G652A + G650A	Holter 12–35 h, your own device (Level 1) Recording + scanning + reading. 3+ channels, patient diary (J16).	\$113.65
G650A	Holter 12–35 h, reading only (Level 1)	\$47.90
G658A	Holter 36–59 h, reading only (Level 1)	\$75.45
G659A	Monitor 60 h–13 days, reading only (Level 1)	\$95.85
G649A	Monitor 14+ days, reading only (Level 1) Once per 30 days (J17).	\$122.25
G682A + G683A + G658A	Holter 36–59 h, your own device (Level 1) Recording + scanning + reading. One code for the whole duration, not multiples of shorter ones (J16–J17).	\$206.95
G684A + G685A + G659A	Monitor 60 h–13 days, your own device (Level 1) Recording + scanning + reading (J16).	\$293.00
G647A + G648A + G649A	Monitor 14+ days, your own device (Level 1) Recording + scanning + reading. Once per 30 days (J17).	\$443.55
G696A	Monitor 14+ days, fewer than 3 electrodes (Level 2), reading Once per 30 days. Patient-activated loop recorders are not insured (J17).	\$86.80
G694A + G695A + G696A	Monitor 14+ days, fewer than 3 electrodes (Level 2), your own device Recording + scanning + reading. Once per 30 days (J16–J17).	\$302.55
G570A + G571A	Complete echo, your accredited lab All cardiac structures plus Doppler (J21).	\$227.00
G571A	Complete echo, reading only	\$96.20
G583A	Stress echo, reading only Not with G570A–G575A (J21).	\$110.15
G575A	Focused echo (one component), reading e.g. follow-up within 2 weeks of a complete study (J23).	\$13.95
G580A + G581A	Transoesophageal echo Probe insertion + reading (J24–J25).	\$70.00
G579A	Saline (bubble) study Add-on to G571A, G574A or G581A.	\$11.35
G283A	Pacemaker reprogramming, single chamber, reading Technical G284A \$10.25 if your equipment.	\$11.30
G180A	Pacemaker reprogramming, dual chamber, reading Technical G181A \$13.40.	\$16.95
G307A	Pacemaker pulse wave analysis, reading Technical G308A \$10.25.	\$9.55
G321A	ICD interrogation and reprogramming Programmable device (J18).	\$47.65
G317A	ICD interrogation, non-programmable	\$27.80
G320A	Reading a phone-transmitted rhythm strip Technical G311A \$2.25 if your equipment (J18).	\$4.30

Z437A	Cardioversion Up to 3 sessions per patient per day (J9).	\$92.45
G517A	Ankle-brachial index	\$10.05
G271A	Warfarin dosing by phone, this month Long-term anticoagulant supervision, per month (J8).	\$13.10

Can I bill these together?

Code	With	Together ?	Why
G319A	A605A, A603A, A604A, A601A, A608A, C605A, C603A, C604A	Sometimes	The stress test reading includes the clinical assessment just before the test (J15). A visit is paid on top only when it's for something more than the pre-test check.
E078A	A601A, A603A, A604A, A608A	No	E078A is only paid to the specialties listed in GP25; Cardiology (60) isn't one of them (GP25).
A605A	A603A, A604A, A601A, A608A, A675A, A606A	No	A consultation already includes the assessment; bill one or the other for the visit (GP16).
A600A	A605A, A603A, A604A, A601A, A608A	No	A600A replaces A605A when you spent 75+ minutes; it already includes the assessment (A79, GP16).
C600A	C605A, C603A, C604A, C601A	No	One consultation or assessment per visit; C600A replaces C605A when 75+ minutes (A80).
E088A	A603A, A604A, A601A, A608A	Yes	E088A adds 50% to these assessments in the office or a hospital clinic, diagnostic code 428 (A79–A80).
E088A	A605A, A600A, A675A, A606A	No	E088A only goes on assessments (A603A, A604A, A601A, A608A), not consultations (A79).
E088A	C603A, C604A, C601A, C602A, C605A	No	E088A isn't paid for in-patients, LTC residents or ED patients (A79).
K013A	A605A, A600A, A603A, A604A, A601A, A608A, A675A, A606A	No	With counselling no consultation or assessment is paid the same day (GP58).
K002A	A605A, A603A, A604A, A601A, A608A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A, K739A	A605A, A600A, A603A, A604A, A601A, A608A, C605A	No	Phone or e-consult isn't paid if you see the patient the same day or the next day; bill the visit (A43, A49).
G313A	G315A, G319A	No	The stress test includes the resting ECGs before and after (J15).
G570A, G571A, G574A, G575A	G582A, G583A	No	A resting or focused echo isn't paid with a stress echo (J21).
G585A	G570A, G582A	Sometimes	Contrast only in a difficult-to-image patient (2+ segments not seen), with the reading G571A or G583A also paid, by a contrast-trained reader (J23).
G650A, G658A, G659A, G649A	G653A, G656A, G657A, G696A	No	One professional component per recording (J16).
G310A, G313A, G571A, G650A	A605A, A603A, A604A, A601A, A608A	Yes	Diagnostic tests are paid on top of the consultation or assessment (J3).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A, E084A	C608A	No	MRP premiums only go on visits by the MRP; concurrent care means someone else is MRP (GP47–48).
C122A, C123A, C142A, C143A	C124A, C126A	No	C122A/C123A/C142A/C143A aren't paid the same day as the discharge visit (GP44, GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C101A	G400A, G401A, G402A, G405A, G406A, G407A, G557A, G558A, G559A	No	C101A isn't paid with critical care, ventilatory or comprehensive care team (per diem) fees (GP103).

Code	With	Together ?	Why
C101A	G521A, G523A, G522A	Yes	GP103 bars C101A only where critical care, ventilatory or comprehensive care team (per diem) fees are claimed; life-threatening critical care G521A–G523A is time-based, not a team fee (GP103, J30).
K001A	A600A	Sometimes	After a comprehensive consultation detention starts only past 120 minutes, for active treatment, not waiting (GP29–31).
Z437A	A605A, A603A, A604A, C605A	Sometimes	Z codes in this section follow the Surgical Preamble (J1): paid on top when today's visit is where you decided to cardiovert. If an elective cardioversion was decided at an earlier visit, only a partial assessment is paid before it that day (SP4).
G521A,G523A,G522A	Z437A, G211A	No	Cardioversion, defibrillation, intubation and lines are included in life-threatening critical care (J26).
G521A,G523A,G522A	G395A	No	Other critical care G395A isn't paid with G521A, G522A or G523A the same day (J28).
G521A,G523A,G522A,G395A	G400A, G401A, G402A, G557A	No	Critical care time codes aren't paid the same day as a critical care, ventilatory or comprehensive care per diem (J27–J28).
G521A,G523A,G522A	A605A, A600A, A603A, A604A, C605A, C603A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and that time isn't counted (J26–J27).
G261A,G259A,G115A	G521A, G523A, G522A, G395A, G391A	No	Arrhythmia induction and external pacing aren't paid with critical care codes (J12–J13).
K730A,K738A	A605A, A600A, A675A, A606A, A603A, A604A, A601A, A608A	Yes	Your own phone consult or e-consult as the referring doctor is paid in addition to visits the same day. Not to arrange a referral, transfer, visit or test, or mainly to discuss results (A42, A48–A49).
K035A,K036A,K070A	A605A, A600A, A675A, A606A, A603A, A604A, A601A, A608A, C605A, C600A, C675A, C606A, C603A, C604A, C601A, C602A, C607A, C609A, C608A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	The MTO report, travel grant form and home care referral form have no same-day rule; paid on top of the visit (A58–A60).
K121A	C605A, C600A, C675A, C606A, C603A, C604A, C601A, C602A, C607A, C609A, C608A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).
K733A	A605A, A600A, A675A, A606A, A603A, A604A, A601A, A608A, C605A, C600A, C675A, C606A, C603A, C604A, C601A, C602A, C607A, C609A, C608A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	Unlike K731A, the CritiCall consultant fee has no rule against seeing the patient the same or next day (A45–A46; only E150A has that rule).
K013A,K033A	K035A, K036A, K730A, K002A, G489A	Yes	On the list of services allowed the same day as counselling (GP58).
K013A,K033A	K070A, K121A, K738A	No	With counselling, only the services listed in GP58 are paid the same day; this isn't one of them (GP58).

Code	With	Together ?	Why
Z442A	Z439A, Z440A, G297A	Sometimes	Both paid, but each additional catheterization procedure at the same sitting is paid at 50% (G262A and G263A excepted) (J9).

From the Ontario Schedule of Benefits (effective July 1, 2026): Cardiology listings A79–A80, General Preamble GP16–GP103 and the Electrocardiography, Echocardiography and Cardiovascular parts of Diagnostic and Therapeutic Procedures (J9–J25), Critical Care (J26–J32) and Cardiovascular Surgical Procedures (Q2–Q5). Cardiology services not listed there are billed from Internal Medicine (A79). Totals leave out the age premium on specialist consultations for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance. Phone visits are shown at the 85% OHIP pays. Test fees with a technical part include it only where you own the equipment; in hospital, bill the professional component. Check your remittance advice if a fee looks different.

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