Diagnostic Radiology OHIP Billing Cheat Sheet 2026

OHIP specialty 33 · X-ray: chest, abdomen or spine · X-ray: arm or leg · CT: head, neck, spine or limb · Updated November 2026

Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/diagnostic-radiology

Pick the modality and the study, tick what else you did, bill the codes at the bottom. Fees shown are the professional part (suffix C); hospital out-patient studies add the technical part (suffix B). Ontario fees effective July 1, 2026.

X-ray: chest, abdomen or spine

X091C	Chest, two views PA and lateral.	$11.70
X090C	Chest, one view e.g. a portable AP film.	$6.95
X092C	Chest, three or more views Only when the extra views are indicated (D3).	$13.55
X101C	Abdomen, two or more views e.g. supine and erect for obstruction.	$10.05
X100C	Abdomen, one view A survey film is a single view (D3).	$7.00
X028C	Lumbar spine, two or three views Doesn't include the whole sacrum (D2).	$8.70
X025C	Cervical spine, two or three views Four or five views: X202 ($11.75).	$8.70
X037C	Pelvis and/or hips, two views e.g. AP and frog, or AP both hips plus lateral one hip.	$10.05

- Read only, or read in a community clinic: bill the C claim alone. The B (technical) claim is paid only for a hospital study, never for an in-patient (D2, GP11).
- Fewer views than the minimum listed? Bill the code at 75% (D2). An abnormal film can justify further views and the bigger code (D2).
- No pay for chest films done only as routine pre-op screening before non-cardiac, non-thoracic surgery, or routinely on admission; there must be a symptom, sign or guideline indication (D3).
- Three or more chest views aren't routine when a chest is requested, and abdomen or pelvis films aren't routine with a lumbar spine request (D3).
- You must be in Ontario when you read the film, and you must read it yourself (D1).

X-ray: arm or leg

X065C	Knee, two views Three or four views: X224 ($9.90).	$7.00
X067C	Ankle, two or three views Four or more: X227 ($9.90).	$7.00
X069C	Foot, two or three views Four or more: X229 ($9.90).	$7.00
X053C	Wrist, two or three views Four or more: X218 ($9.90).	$7.00
X054C	Hand, two or three views Wrist and hand together: X055 ($14.25).	$7.00
X048C	Shoulder, two views Three or more: X212 ($11.60).	$8.70
X051C	Elbow, two views Three or four: X215 ($9.90).	$7.00
X060C	Hip, one side, two or more views	$8.35
X057C	Bone age, single film Only when you compare the film against a standard atlas yourself. Two or more films: X058 ($15.70) (D9).	$13.05

- Each listing is one side. Comparison films of the other side that you started yourself aren't billable when one limb was requested (D2).
- Abnormal findings, or views that won't answer the question: add views and bill the bigger code, e.g. knee 5+ views X225 ($12.70) instead of X065 ($7.00) (D2, D8).
- A stereo pair counts as two views. The image intensifier adds nothing (D2).

- Fewer views than the minimum: 75% of the listed fee (D2).

CT: head, neck, spine or limb

X400C	Head, no contrast	$43.25
X401C	Head, with IV contrast	$64.95
X188C	Head, without and with IV contrast	$75.85
X402C	Complex head, no contrast Multiplanar: pituitary or posterior fossa, IAMs, orbits, temporal bone or TMJs (D2).	$64.95
X408C	Complex head, without and with IV contrast With contrast only: X405 ($75.85).	$86.60
X404C	Neck, with IV contrast No contrast X403 ($86.60); both X124 ($108.30).	$97.50
X415C	Spine, no contrast One or more segments. With contrast X416 ($97.50).	$86.60
X412C	Arm or leg, no contrast One or more extremities. With contrast X413 ($64.95).	$43.25

- CT has only a professional fee: bill suffix C, in or out of hospital (D18).
- A multiplanar study of the pituitary or posterior fossa, IAMs, orbits, temporal bone or TMJs is complex head, X402–X408, which pays more. Don't add X400, X401 or X188 to it (D2).
- Acute stroke perfusion read in the treatment window: E874C ($64.00) on top of the head CT. It includes its own contrast, so when the perfusion is the only contrast study bill it with the plain head CT (X400 or X402), not X401 or X405 (D18).
- Urgent after-hours read by PACS from outside the hospital: E406A $60, E407A $75, E408A $100, once per patient per day. Send the report within 3 hours of the scan and chart the request and transmission times (GP107–GP108).
- Lumbar spine CT for low back pain without suspected or known pathology shouldn't be done routinely (D3–D4).

CT: chest, abdomen, pelvis or heart

X410C	Abdomen, with IV contrast Tick the pelvis below if scanned too.	$97.50
X409C	Abdomen, no contrast	$86.60
X126C	Abdomen, without and with IV contrast	$108.30
X407C	Thorax, with IV contrast	$75.85
X406C	Thorax, no contrast	$64.95
X125C	Thorax, without and with IV contrast	$86.60
X235C	Cardiac CT (coronary CTA) 64-slice scanner or better, listed indications only; includes beta blockers, IV and 3D work (D19).	$147.50
X234C	CT colonography Listed indications only; 16-detector scanner or better; includes 3D work, contrast and faecal tagging (D21–D22).	$235.30

- Abdomen and pelvis are listed separately: scan both and bill both, e.g. X410 + X232 = $195.00 (D21).
- Cardiac CT X235 ($147.50) already includes 3D work and contrast: no X417, X406, X407 or X125 with it. Not for calcium scoring alone or screening without symptoms (D19–D20).
- CT colonography X234 ($235.30) replaces the abdomen and pelvis codes and X417 (D21).
- Max one X417 per patient per day (D23).
- PACS after-hours premiums aren't paid on top of a second-opinion read (A330A) (A193).

MRI

X421C	Head Each extra plane or pulse sequence below, up to 2.	$73.35
X490C	Spine, one segment	$59.50
X493C	Spine, two adjoining segments	$68.45
X496C	Spine, two or more segments not adjoining	$101.65
X471C	One joint or one extremity Shoulder, elbow, wrist, hip, knee or ankle (F4).	$62.80
X488C	Two or more joints, or two extremities, one sitting Separate coil, sequence, filming and post-processing for each joint (F4).	$108.80
X451C	Abdomen Not when the MRI is guidance for an organ biopsy (F2).	$73.35
X461C	Pelvis	$73.35

- Every extra plane or pulse sequence is a repeat code: up to 2 on the head, 3 elsewhere. Head with 2 repeats pays $146.75 against $73.35 for the first sequence alone (F2).
- Two or more joints in one sitting, each with its own coil, sequence and post-processing: X488 ($108.80) instead of X471 (F4).
- Gadolinium adds X487 ($36.65) (F4). Neck X431 and thorax X441 pay $73.35 like the head (F2).
- Lumbar MRI shouldn't be done routinely for low back pain without suspected pathology (F1).
- Breast MRI: use the Breast tile. Thorax MRI isn't paid the same day to the same physician as breast MRI (F3).

Ultrasound

J135C	Abdomen, complete	$28.85
J128C	Abdomen, limited e.g. gallbladder only, aorta only, or a follow-up.	$17.55
J162C	Pelvis, complete For ovulation induction, max 1 per cycle; more are J164 (G6).	$26.55
J138C	Intracavitary (transvaginal or transrectal) Limited, not pregnancy: J161 ($16.25). Ovulation induction: max 1 per cycle, more are J164 (G6).	$26.50
J105C	Neck or face (thyroid, nodes) Not vascular; not for the sinuses (G3).	$23.70
J183C	Scrotum	$25.95
J182C	Arm or leg (joint, soft tissue), per limb Not vascular.	$14.95
J201C	Carotids, duplex Both sides, with spectral analysis. Doppler or B scan only: J190 ($17.10).	$24.65
J202C	Arm or leg vessels, duplex, per limb Distal to the groin or axilla. Doppler or B scan only: J193 ($14.30).	$16.60

- Out of hospital, only the C claim is billable; in a hospital out-patient clinic add the B claim (G1–G2, GP11).
- Comparison scans you start yourself when one area was requested aren't paid (G2).
- Transvaginal or transrectal (J138, J161) pays nil with sonohysterography (J165) or with ultrasound guidance (J149) the same visit (G6, G11).
- Carotids: one of J190 or J201 per day; duplex J201 pays more. Limbs: one of J193 or J202 per extremity per day (G7).
- Residual urine G900A isn't paid with a pelvic or intracavitary scan (G6). Not insured when done to support IVF or insemination (G2).

Pregnancy ultrasound

J159C	Complete, 16 weeks or later, normal pregnancy Max 1 per normal pregnancy (G5).	$33.80
J160C	Complete, high-risk or complicated pregnancy No per-pregnancy maximum listed.	$32.25
J158C	Limited, high-risk or complicated pregnancy	$17.55
J157C	Dating for maternal serum screening, before 16 weeks Max 1 per normal pregnancy (G5).	$17.55
J168C	Nuchal translucency (prenatal genetic screening) Max 1 per pregnancy; no other abdomen, pelvis or pregnancy scan that day (G5).	$20.85

- High-risk or complicated pregnancy: J160 and J158 have no per-pregnancy limit; J159 and J157 are once per normal pregnancy (G5).
- On the nuchal translucency day (J168), no other abdominal, pelvic or pregnancy ultrasound by any physician is paid (G5).
- Twins or more: J166 per extra fetus with J160, J169 with J168 (G5).
- A midwife's referral is insured for pregnancy and postpartum pelvic scans in a hospital or ICHSC; a nurse practitioner's for any listed study there (GP111).

Breast: mammogram, ultrasound, MRI

X185C	Mammogram, both breasts, signs or symptoms Symptoms, a finding, or follow-up of known disease (D24).	$33.85
X178C	Mammogram, both breasts, no signs or symptoms Requested only for a risk factor, per guidelines (D24).	$33.85
X184C	Mammogram, one breast, signs or symptoms	$21.15
X172C	Mammogram, one breast, no signs or symptoms	$21.15
J127C	Breast ultrasound, one breast Per breast.	$14.30
X446C	Breast MRI (one or both) Not for screening an average-risk woman; not as biopsy guidance (F2–F3).	$73.35

- Tomosynthesis adds 50% to the mammogram's C fee with E448C: X185 + E448C pays $50.78 against $33.85 (D24).
- X169 (tomogram) and X417 aren't paid with a mammogram. A second mammogram the same day by another modality: send it with the manual review indicator (D24).
- Chest films aren't routine in mammography cases (D3). Extra coned views: max 2 per breast (D24).
- Breast MRI isn't paid as the guidance for a biopsy; bill X480 ($285.00) when only MRI can show the lesion (F2).

Bone density (DXA)

X146C	Baseline, two or more sites Once per lifetime. Hip and spine both, unless one isn't feasible (D16).	$48.00
X148C	Repeat, not high-risk, two or more sites Once every 60 months or longer (D16).	$48.00
X155C	Repeat, high-risk or therapy monitoring, two or more sites Once every 36 months (D17).	$48.00
X236C	Extra test for a specific risk factor, two or more sites Once every 12 months at most (D17).	$48.00
X145C	Baseline, one site Once per lifetime.	$40.15
X149C	Repeat, high-risk or therapy monitoring, one site Once every 36 months. Not high-risk: X142; risk factor: X237.	$40.15

- Insured only to assess or manage osteoporosis or low bone mass. Two or more sites must include hip and spine unless one isn't feasible (D16).
- High-risk means T-score -2.5 or lower, a hip or spine fracture or 2+ other fractures, or 10-year risk 15%+ (D16).
- The interval counts from the last BMD of any kind: 60 months for not high-risk, 36 for high-risk or therapy monitoring, 12 for a specific risk factor (D16–D17).
- Specific risk factor (X236/X237): secondary osteoporosis risk, a new fragility fracture, or rapid bone loss. Keep the reason; the ministry can ask (D17).

Fluoroscopy and contrast studies

X104C	Upper GI, double contrast Gas, antifoam and barium (D3). Single contrast: X108 ($41.65).	$50.65
X103C	Upper GI, double contrast, plus small bowel	$63.75
X113C	Colon, air contrast Well-prepared colon, 5–8 full-size views after fluoroscopic air and barium (D3).	$54.35
X112C	Colon, barium enema	$32.10
X130C	IVP, with the preliminary film Rapid sequence and nephrotomography add nothing (D3).	$24.85
J001A + X156C	Arthrogram, tenogram or bursogram Injection J001 plus the imaging X156 (E1, E4).	$82.10
J011A + X173C	Myelogram Injection J011 plus the imaging X173. Supine views with a new needle: J038; posterior fossa: J020.	$131.70
J008A + X147C	Hysterosalpingogram Procedure J008 plus the imaging X147.	$69.10
J028A + X135C	Voiding cystourethrogram (catheter) Procedure J028 plus the imaging X135.	$65.90

- The injection or catheter (J code, suffix A) is billed with the X imaging fee: a myelogram is J011 + X173 = $131.70 (E1).
- No fluoroscopy codes (X195–X197) on GI, urinary or special studies where fluoroscopy is part of the exam (D3).
- Chest or abdomen films aren't routine with a GI study; X106 isn't routine with X108 or X109 (D3).
- Fluoroscopy for another physician's procedure: X189 per 15 min ($36.40) (D14).

Interventional procedure

J021A	Catheter angiogram: catheter and injection Add the angiogram images and any selective vessels below (E1–E2).	$186.05
J025A	Angioplasty Includes the angiogram when the anatomy is known (E2).	$610.10
J040A	Embolization, first vessel Plus the angiographic procedure and imaging fees (E3).	$185.90
S350A	Embolization for active GI bleeding All-inclusive: access, selective catheters, embolization and all imaging. IR suite only (E6).	$1,500.00
S351A	Uterine, prostate or thoracic duct embolization All-inclusive, like S350A (E6).	$700.00
J057A	TIPS	$1,389.60
J046A	Percutaneous nephrostomy	$394.90
J055A	Percutaneous gastrostomy Cecostomy J061 and cholecystostomy J062 pay the same; jejunostomy J063 ($458.05).	$394.90
J069A	Thermal ablation of a solid tumour CT or US guidance included; guideline criteria (E5).	$790.25

- Non-elective after hours, the procedure fee (not the X imaging fee) pays 50% more (weekday evenings, weekend and holiday days and evenings) or 75% more (nights 00–07) with E409A/E410A (GP104).
- Angioplasty with known anatomy already includes the angiogram: no J021/J022. Anatomy unknown: J021/J022 at 50%. Second side same sitting: second angioplasty at 50% (E2).
- S350A and S351A include everything: no other angiography or imaging fee, for any physician (E6).
- J064 tube exchange and J069 ablation include all image guidance: no imaging fee to anyone (E5).
- J058 stent pays nil with G298A the same day; J021/J022 not with cardiac catheterization (E2).

Consultation or second opinion

A335A	Consultation Outside films or ultrasounds sent to you for a written opinion, or after-hours visit where the procedure isn't done, or pre-procedure opinion away from your suite (A192).	$57.90
C335A	Consultation, hospital in-patient Same conditions as A335A (A193).	$57.90
A365A	Special interventional consultation, 50+ min Pre-procedure consult away from your suite for a listed procedure, 50+ minutes face to face (A192).	$258.35
A330A	Second opinion of an outside CT, per region Max 1 per region per patient per 30 days (A193).	$103.60
A332A	Second opinion of an outside MRI, per region Max 1 per region per patient per 30 days (A193).	$231.15
A338A	Saw the patient, decided not to do the study Non-emergent (A193).	$26.80
A331A	Saw the patient, study cancelled or deferred Non-emergent; procedural difficulty such as lack of cooperation; no other study done (A193).	$26.80
A881A	Dosimetry planning for radioembolization Per course of treatment.	$200.00

- Outside CT or MRI for your written opinion: A330A ($103.60) or A332A ($231.15) per region, not A335A. Needs the written request and your report on the chart (A192–A193).
- No consult when the outside images are only for comparison with your own study (A192–A193).
- Came in after hours and decided against the procedure? A335A plus the special visit premium (A192, GP105). Non-emergent, not a special visit: A338A (A193).
- A365A needs 50+ minutes face to face before a listed procedure (e.g. J021, J025, J046, J055, J057), not counting other billable work (A192).

Also bill, if it's true

C102A + C109A	Came in Mon–Fri 17–24: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). Max 2 per period.	$99.10
C103A + C108A	Came in Sat, Sun or holiday 07–24: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). Max 6 per period.	$114.50
C104A + C110A	Came in at night 00–07: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). No maximum.	$140.20
C105A	Same trip, another patient (Mon–Fri 17–24) Each further patient seen on the same special visit (GP105–GP106).	$61.70
C106A	Same trip, another patient (weekend or holiday) Each further patient seen on the same special visit (GP105–GP106).	$77.10
C107A	Same trip, another patient (night) Each further patient seen on the same special visit (GP105–GP106).	$102.80
E406A	Urgent read by PACS, Mon–Fri 17–24 Read from outside the hospital (in Ontario) for an in-patient, ED or urgent care patient; referrer has privileges there, you have radiology privileges there, report sent within 3 h. 1 per patient per day; max 2 per period. Chart request and transmission times (GP107–GP109).	$60.00
E407A	Urgent read by PACS, Sat, Sun or holiday 07–24 Same conditions as E406A. Max 6 per period (GP107–GP109).	$75.00
E408A	Urgent read by PACS, night 00–07 Same conditions as E406A. No maximum (GP107–GP109).	$100.00
C102A + C109A	Came in Mon–Fri 17–24: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). Max 2 per period.	$99.10
C103A + C108A	Came in Sat, Sun or holiday 07–24: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). Max 6 per period.	$114.50
C104A + C110A	Came in at night 00–07: travel + first patient Non-elective in-patient, out-patient or ED patient; you came to the hospital for an urgent read that changes management, a procedure, a consult, or to decide not to do it. Not for PACS reads, 1 person-seen premium per patient, not with any other special visit premium (GP105). No maximum.	$140.20
C105A	Same trip, another patient (Mon–Fri 17–24) Each further patient seen on the same special visit (GP105–GP106).	$61.70
C106A	Same trip, another patient (weekend or holiday) Each further patient seen on the same special visit (GP105–GP106).	$77.10
C107A	Same trip, another patient (night) Each further patient seen on the same special visit (GP105–GP106).	$102.80
X417C	3D acquisition and post-processing Min 60 slices; max 1 per patient per day. Not with X235 or X234 (D19, D21, D23).	$32.70
E874C	CT perfusion for acute stroke Read in the treatment window. Includes its contrast and the perfusion maps: with a plain head CT bill X400/X402 + E874C, not a contrast head code for it (D18).	$64.00
X232C	Pelvis too, with IV contrast Each region is its own code (D21).	$97.50
X231C	Pelvis too, no contrast	$86.60
X233C	Pelvis too, without and with contrast	$108.30

X410C	Abdomen too, with IV contrast Each region is its own code (D21).	$97.50
X409C	Abdomen too, no contrast	$86.60
X232C	Pelvis too, with IV contrast	$97.50
X425C	Each extra plane or pulse sequence Max 2 repeats (F2).	$36.70
X492C	Each extra plane or pulse sequence Max 3 repeats (F4).	$29.85
X495C	Each extra plane or pulse sequence Max 3 repeats (F4).	$34.15
X498C	Each extra plane or pulse sequence Max 3 repeats (F4).	$50.65
X475C	Each extra plane or pulse sequence Max 3 repeats (F4).	$31.45
X489C	Each extra plane or pulse sequence Max 3 repeats (F4).	$54.35
X455C	Each extra plane or pulse sequence Max 3 repeats (F2).	$36.70
X465C	Each extra plane or pulse sequence Max 3 repeats (F4).	$36.70
X447C	Each extra plane or pulse sequence Max 3 repeats (F2).	$36.70
E875C	MR spectroscopy or fibre tracking On the head sequence. Max 1 per patient per day (F2).	$19.40
E876C	Spectroscopy or fibre tracking on a repeat sequence too Goes with X425. Max 1 per patient per day (F2).	$9.70
X458C	Liver elastography (fat or iron) (F2).	$36.70
X487C	Gadolinium given (F4).	$36.65
X499C	3D acquisition and post-processing Min 60 slices; max 1 per patient per day (F5).	$32.70
E448C	3D tomosynthesis +50% of the mammogram's professional fee (D24).	+50%
X194C	Extra coned or magnified view, per film Max 2 per breast (D24).	$5.65
J127C	Breast ultrasound too, per breast (G10).	$14.30
J127C	Other breast too Per breast (G10).	$14.30
X487C	Gadolinium given (F4).	$36.65
J162C	Pelvis too, complete Transabdominal pelvis, its own code (G6).	$26.55
J138C	Transvaginal or transrectal too Nil with J165 sonohysterography or J149 guidance the same visit (G6, G11).	$26.50
J202C	Other limb too One J193 or J202 per extremity per day (G7).	$16.60
J182C	Each other limb Per limb (G10).	$14.95

E447C	Two or more large joints on the same limb Shoulder, elbow, hip, knee or ankle: +25% of J182C (G10).	+25%
E475C	Portable scan outside the imaging department, per 15 min Done personally by a radiologist (33), in the hospital outside DI. Per unit = 15 min or major part; chart start and stop times (G10, GP7).	$27.30
J166C	Each additional fetus Multiple gestation, with J160 (G5).	$22.10
J167C	Fetal Doppler: MCA and/or ductus venosus Only for fetal anaemia, growth restriction (EFW or AC under 10th percentile, or a 30+ percentile drop), or a high-risk pregnancy (G5).	$30.00
J169C	Each additional fetus Multiple gestation, with J168 (G5).	$16.35
J138C	Transvaginal scan too Not on the J168 day (G5).	$26.50
X181C	Angiogram images, non-selective Film changer, cine or multiformat camera. Single films: X179 ($15.85) (D15).	$47.35
J022A + X182C	Each selective vessel Catheter J022 plus images X182, per vessel, max 4. Five or more vessels: images X140 ($185.60) instead (E2, D15).	$149.55
J035A	Pressure measurements during the angiogram (E3).	$52.10
J047A	Each additional vessel catheterized and occluded (E3).	$87.05
E409A	Non-elective, Mon–Fri 17–24 or weekend/holiday 07–24: +50% Clinical procedures (this section) done non-electively, or an elective case delayed by an emergency. On the procedure fees only, not the X imaging fees; not for an ED physician (GP103–GP104).	+50%
E410A	Non-elective, night 00–07: +75% Same conditions as E409A (GP104).	+75%
E409A	Non-elective after hours: +50% (night +75%, E410A) on the J procedure On the J code only, not the X imaging fee. OHIP computes it; the total here leaves it out (GP104).	
J038A	Supine views needing the needle re-introduced (E5).	$23.75
J020A	Posterior fossa views (E5).	$26.05
X091B	Hospital out-patient: bill the technical part too X091B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$21.90
X090B	Hospital out-patient: bill the technical part too X090B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X092B	Hospital out-patient: bill the technical part too X092B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$28.15
X101B	Hospital out-patient: bill the technical part too X101B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$22.80
X100B	Hospital out-patient: bill the technical part too X100B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90

X028B	Hospital out-patient: bill the technical part too X028B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$25.90
X025B	Hospital out-patient: bill the technical part too X025B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$25.90
X037B	Hospital out-patient: bill the technical part too X037B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$27.75
X065B	Hospital out-patient: bill the technical part too X065B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X067B	Hospital out-patient: bill the technical part too X067B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X069B	Hospital out-patient: bill the technical part too X069B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X053B	Hospital out-patient: bill the technical part too X053B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X054B	Hospital out-patient: bill the technical part too X054B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X048B	Hospital out-patient: bill the technical part too X048B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$17.95
X051B	Hospital out-patient: bill the technical part too X051B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
X060B	Hospital out-patient: bill the technical part too X060B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$23.75
X057B	Hospital out-patient: bill the technical part too X057B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$14.90
J135B	Hospital out-patient: bill the technical part too J135B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$48.75
J128B	Hospital out-patient: bill the technical part too J128B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$32.10

J162B	Hospital out-patient: bill the technical part too J162B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$48.75
J138B	Hospital out-patient: bill the technical part too J138B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$48.75
J105B	Hospital out-patient: bill the technical part too J105B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$47.30
J183B	Hospital out-patient: bill the technical part too J183B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$47.30
J182B	Hospital out-patient: bill the technical part too J182B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$25.50
J201B	Hospital out-patient: bill the technical part too J201B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$55.05
J202B	Hospital out-patient: bill the technical part too J202B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$28.50
J159B	Hospital out-patient: bill the technical part too J159B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$48.75
J160B	Hospital out-patient: bill the technical part too J160B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$48.75
J158B	Hospital out-patient: bill the technical part too J158B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$32.10
J157B	Hospital out-patient: bill the technical part too J157B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$32.10
J168B	Hospital out-patient: bill the technical part too J168B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$39.00
X185B	Hospital out-patient: bill the technical part too X185B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$37.15
X178B	Hospital out-patient: bill the technical part too X178B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$37.15

X184B	Hospital out-patient: bill the technical part too X184B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$28.05
X172B	Hospital out-patient: bill the technical part too X172B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$28.05
J127B	Hospital out-patient: bill the technical part too J127B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (G1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (G2).	$23.70
X146B	Hospital out-patient: bill the technical part too X146B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$55.20
X148B	Hospital out-patient: bill the technical part too X148B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$55.20
X155B	Hospital out-patient: bill the technical part too X155B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$55.20
X236B	Hospital out-patient: bill the technical part too X236B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$55.20
X145B	Hospital out-patient: bill the technical part too X145B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$42.85
X149B	Hospital out-patient: bill the technical part too X149B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$42.85
X104B	Hospital out-patient: bill the technical part too X104B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$48.50
X103B	Hospital out-patient: bill the technical part too X103B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$60.95
X113B	Hospital out-patient: bill the technical part too X113B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$61.30
X112B	Hospital out-patient: bill the technical part too X112B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$48.40
X130B	Hospital out-patient: bill the technical part too X130B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$49.65

X156B	Hospital out-patient: bill the technical part too X156B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$26.25
X173B	Hospital out-patient: bill the technical part too X173B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$34.95
X147B	Hospital out-patient: bill the technical part too X147B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$29.80
X135B	Hospital out-patient: bill the technical part too X135B, paid only for a study done in a hospital or its approved off-site premises, and not for an in-patient or a patient admitted to the same hospital within 24 h for the same problem (D1, GP11). Community clinic (ICHSC): the facility is paid the technical cost instead (D2).	$27.50

Did a guided or interventional procedure?

J149C	Ultrasound guidance of biopsy, aspiration, amniocentesis or drainage One physician only. Hospital: J149B ($47.30) too. J138/J161 the same visit pay nil (G11).	$56.45
X168C	CT guidance of biopsy (D23).	$42.50
X481C	MRI guidance of biopsy or ablation, internal organ Only when the lesion shows only on MRI or other guidance isn't feasible. Not with X451/X455 (F2).	$285.00
X480C	MRI guidance of breast biopsy or ablation Same conditions. Not with X446/X447 (F2).	$285.00
X121C	Stereotactic core breast biopsy (D15).	$90.75
J004A	Needle localization under mammography (E4).	$76.75
X201C	Biopsy specimen X-ray, per specimen (D24).	$5.65
J062A	Percutaneous cholecystostomy (E5).	$394.90
J064A	Drainage tube exchange or replacement IR suite under imaging only; includes all imaging (E5).	$99.90
J013A + X122C	Percutaneous transhepatic cholangiogram Procedure plus imaging (E6, D15).	$211.15
J059A	Non-vascular stent (E5).	$179.20
J065A	Dilation of a non-vascular structure (E5).	$36.15
J058A	Vascular stent Nil with G298A the same day (E2).	$101.55
J066A	Renal angioplasty (E2).	$773.25
J045A + X138C	Percutaneous antegrade pyelogram Procedure plus imaging (E5, D12).	$225.25
J039A	Renal cyst puncture (E6).	$215.25
J006A + X164C	Discogram, one disc Each further disc: J030 ($54.05) (E4, D24).	$130.40
J010A	Lymphangiogram, per side Imaging X171 ($25.15) (E5, D24).	$114.90
J068A	Reduction of intussusception (E4).	$48.30
J036A + X167C	Fistula or sinus injection Procedure plus imaging (E4, D24).	$46.95
J018A + X176C	Sialogram Procedure plus imaging (E6, D24).	$92.50
Z597A	Intracavitary or intratumoural injection (E6).	$159.05
J151C	Compression of a groin pseudoaneurysm, per 15 min (G11).	$21.45
X189C	Fluoroscopy for another physician's procedure, per 15 min Hospital: X189B ($7.30) too (D14).	$36.40

Can I bill these together?

Code	With	Together?	Why
X400,X400C,X401,X401C,X188,X188C	X402, X402C, X405, X405C, X408, X408C	No	X400, X401 and X188 aren't billed with a complex head study (D2 note 9).
X235,X235C	X417, X417C, X406, X406C, X407, X407C, X125, X125C	No	X417, X406, X407 and X125 aren't paid with cardiac CT X235, which includes 3D work and contrast (D19).
X234,X234C	X417, X417C, X409, X409C, X410, X410C, X126, X126C, X231, X231C, X232, X232C, X233, X233C	No	CT colonography X234 isn't paid with X417 or the abdomen and pelvis CT codes (D21).
X169,X169C,X169B,X417,X417C	X172, X172C, X172B, X178, X178C, X178B, X184, X184C, X184B, X185, X185C, X185B	No	X169 and X417 aren't paid with a mammogram (D24).
E448A,E448C	X172, X172C, X172B, X178, X178C, X178B, X184, X184C, X184B, X185, X185C, X185B	Yes	Tomosynthesis E448C adds 50% to the mammogram's professional fee (D24).
E874A,E874C	X400, X400C, X402, X402C	Yes	For acute stroke, read in the treatment window: E874C goes on the plain head CT and includes its own contrast (D18).
E874A,E874C	X401, X401C, X405, X405C	Sometimes	E874C includes the contrast for the perfusion. When the perfusion is the only contrast study, bill the plain head code with it, not X401/X405 (D18).
X409,X409C,X410,X410C,X126,X126C	X231, X231C, X232, X232C, X233, X233C	Yes	Abdomen and pelvis are listed as separate CT studies, each with its own code (D21).
A330A,C330A,A332A,C332A	E406A, E407A, E408A	No	After-hours CT/MRI premiums aren't paid with a second-opinion read (A193).
A335A,C335A	X400, X400C, X401, X401C, X188, X188C, X402, X402C, X405, X405C, X408, X408C, X403, X403C, X404, X404C, X124, X124C, X406, X406C, X407, X407C, X125, X125C, X409, X409C, X410, X410C, X126, X126C, X231, X231C, X232, X232C, X233, X233C, X412, X412C, X413, X413C, X127, X127C, X415, X415C, X416, X416C, X128, X128C, X421, X421C, X451, X451C, X461, X461C, X471, X471C, X490, X490C, X493, X493C, X496, X496C	No	A335A isn't paid for CT or MRI; an outside CT or MRI opinion is A330A or A332A (A192).

Code	With	Together?	Why
A331A	X090, X090C, X090B, X091, X091C, X091B, X092, X092C, X092B, X100, X100C, X100B, X101, X101C, X101B, X028, X028C, X028B, X025, X025C, X025B, X037, X037C, X037B, X065, X065C, X065B, X067, X067C, X067B, X069, X069C, X069B, X053, X053C, X053B, X054, X054C, X054B, X048, X048C, X048B, X051, X051C, X051B, X060, X060C, X060B, X400, X400C, X409, X409C, X410, X410C, X421, X421C, J135, J135C, J135B, J128, J128C, J128B, J162, J162C, J162B, J138, J138C, J138B, J105, J105C, J105B, J183, J183C, J183B, J182, J182C, J182B, J201, J201C, J201B, J202, J202C, J202B, X104, X104C, X104B, X113, X113C, X113B, X130, X130C, X130B, X185, X185C, X185B, X178, X178C, X178B	No	A331A is only when no other diagnostic radiology procedure is rendered (A193).
A338A	X090, X090C, X090B, X091, X091C, X091B, X092, X092C, X092B, X100, X100C, X100B, X101, X101C, X101B, X028, X028C, X028B, X025, X025C, X025B, X037, X037C, X037B, X065, X065C, X065B, X067, X067C, X067B, X069, X069C, X069B, X053, X053C, X053B, X054, X054C, X054B, X048, X048C, X048B, X051, X051C, X051B, X060, X060C, X060B, X400, X400C, X409, X409C, X410, X410C, X421, X421C, J135, J135C, J135B, J128, J128C, J128B, J162, J162C, J162B, J138, J138C, J138B, J105, J105C, J105B, J183, J183C, J183B, J182, J182C, J182B, J201, J201C, J201B, J202, J202C, J202B, X104, X104C, X104B, X113, X113C, X113B, X130, X130C, X130B, X185, X185C, X185B, X178, X178C, X178B	Sometimes	A338A pays for assessing a study that ends up not done; the study you do perform is billed on its own (A193).
J021,J022	J025	Sometimes	Not with angioplasty when the anatomy is known. Anatomy unknown: claim J021/J022 at 50% (E2).

Code	With	Together?	Why
J021,J022	Z439A, G288A	No	J021 and J022 aren't paid with cardiac catheterization procedures, Z439A to G288A (E2).
J058	G298A	No	J058 the same patient, same day as G298A pays nil (E2).
S350A,S351A	J021, J022, J014, J040, J047, X179, X179C, X179B, X180, X180C, X180B, X181, X181C, X181B, X182, X182C, X182B, X140, X140C, X140B, X189, X189C, X189B	No	S350A and S351A include access, selective catheters, embolization and all imaging; no other angiography or imaging fee (E6).
J064,J069	X189, X189C, X189B, X195, X195C, X195B, X196, X196C, X196B, X197, X197C, X197B, J149, J149C, J149B, X168, X168C, X409, X409C, X410, X410C, X126, X126C, J135, J135C, J135B, J128, J128C, J128B	No	J064 and J069 include all image guidance, by any physician; obtaining and reading the images isn't paid (E5).
J021	X179, X179C, X179B, X180, X180C, X180B, X181, X181C, X181B, X182, X182C, X182B, X140, X140C, X140B	Yes	Radiological fees are claimed in addition to the clinical procedure (E1).
J001	X156, X156C, X156B	Yes	Radiological fees are claimed in addition to the clinical procedure (E1).
J011	X173, X173C, X173B	Yes	Radiological fees are claimed in addition to the clinical procedure (E1).
E409A,E410A	J001, J011, J008, J028, J021, J025, J040, J046, J055, J057, J062, J069, J013	Sometimes	Only for a non-elective procedure, or an elective one delayed by an emergency, in the after-hours periods; not by an ED physician (GP103–GP104).
X195,X195C,X195B,X196,X196C,X196B,X197,X197C,X197B	X103, X103C, X103B, X104, X104C, X104B, X108, X108C, X108B, X109, X109C, X109B, X112, X112C, X112B, X113, X113C, X113B, X130, X130C, X130B, X135, X135C, X135B, X156, X156C, X156B, X173, X173C, X173B, X147, X147C, X147B	No	Fluoroscopy isn't claimed where it's an integral part of the exam: GI, urinary and special studies (D3 note 16).
X006,X006C,X006B	X007, X007C, X007B	Sometimes	Mandible and TMJ films aren't both claimed routinely, only when each is ordered (D2 note 11).
X106,X106C,X106B	X108, X108C, X108B, X109, X109C, X109B	Sometimes	X106 isn't claimed routinely with X108 or X109, only when specifically indicated (D3 note 19).
X441,X441C,X445,X445C	X446, X446C, X447, X447C	No	Thorax MRI isn't paid the same day, same physician, as breast MRI (F3).
X446,X446C,X447,X447C	X480, X480C	Sometimes	Breast MRI codes aren't paid when the MRI is the guidance for the biopsy; X480 is (F2).
X451,X451C,X455,X455C	X481, X481C	Sometimes	Abdomen MRI codes aren't paid when used as guidance for an organ biopsy; X481 is (F2).

Code	With	Together?	Why
X487,X487C,X499,X499C	X480, X480C, X481, X481C	Yes	X487 and/or X499 may be paid with MRI-guided biopsy (F2).
J138,J138C,J138B,J161,J161C,J161B	J165, J165C, J165B, J149, J149C, J149B	No	J138 and J161 with sonohysterography or ultrasound guidance the same visit pay nil (G6, G11).
J168,J168C,J168B	J135, J135C, J135B, J128, J128C, J128B, J162, J162C, J162B, J163, J163C, J163B, J138, J138C, J138B, J161, J161C, J161B, J164, J164C, J164B, J165, J165C, J165B, J476, J476C, J476B, J159, J159C, J159B, J160, J160C, J160B, J157, J157C, J157B, J158, J158C, J158B, J166, J166C, J166B, J167, J167C, J167B	No	No abdomen, pelvis or pregnancy ultrasound by any physician the same day as J168 (G5).
J190,J190C,J190B	J201, J201C, J201B	No	Only one of J190 or J201 per patient per day (G7).
J193,J193C,J193B	J202, J202C, J202B	Sometimes	Only one of J193 or J202 per extremity per day; the other limb can have its own (G7).
J189,J189C	J186, J186C, J187, J187C, J188, J188C	No	J189 isn't paid with J186, J187 or J188 the same day; only one of those three per day (G7).
G900A	J162, J162C, J162B, J163, J163C, J163B, J138, J138C, J138B, J161, J161C, J161B	No	Residual urine by ultrasound isn't paid with a pelvic or intracavitary ultrasound (G6).
G517A	J200, J200C, J200B	No	G517A isn't paid with J200 (G9).
X145,X145C,X145B,X146,X146C,X146B	X142, X142C, X142B, X148, X148C, X148B, X149, X149C, X149B, X155, X155C, X155B, X236, X236C, X236B, X237, X237C, X237B	No	One BMD test at a time; each repeat has its own interval from the last BMD of any kind (D16–D17).
X145,X145C,X145B	X146, X146C, X146B	No	One baseline BMD per lifetime (D16).
C102A,C103A,C104A,C109A,C108A,C110A,C105A,C106A,C107A	E406A, E407A, E408A	No	The special visit premiums are for coming to the hospital, never for PACS reads; E406A–E408A are for reading by PACS from elsewhere (GP105, GP107).
C102A,C103A,C104A,C109A,C108A,C110A	A335A, C335A, A365A, C365A, J021, J046, X400, X409, X410, J135, X091	Sometimes	Paid on top of the read, procedure or consult for a non-elective hospital patient seen on a special visit; for a read, only when it's urgent and changes management (GP105).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (A192–A193, D1–D25, E1–E6, F1–F5, G1–G11, GP11, GP103–GP111). Lookup fees are the professional part (C); the technical part (B) is shown where the Schedule lists one and is paid only for hospital studies, never for in-patients or patients admitted within 24 hours for the same problem (GP11). Fewer than the minimum views: 75% of the fee (D2). Clinical procedures (J001–J069, S350A, S351A) are claimed with suffix A; # means premises aren't included (E1). The total leaves out E409A/E410A when the study fee is part of the level, and doesn't apply minimum-view reductions.

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