

Emergency Medicine OHIP Billing Cheat Sheet 2026

OHIP specialty 12 · Weekday daytime · Mon–Thu evening · Fri evening, weekend or holiday · Updated October 2026

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

On shift in the ED or a hospital urgent care clinic: pick when you saw the patient, how much you did, then tick add-ons and procedures. Ontario fees effective July 1, 2026.

Weekday daytime

H103A	Detailed look at more than one system Detailed history and exam of more than one system, part or region.	\$46.65
H102A	Full workup, treated and followed over hours Full history (systems review, past history, meds, social), full exam, treatment, and coming back to the patient over many hours. Includes reading tests and calls to family doctor, family or agencies.	\$56.70
H101A	Minor problem Brief history and exam of one area.	\$22.65
H104A	Re-assessment, 2+ hours later Seen again at least 2 hours after your last assessment and more care or tests were needed. Limit: 2 per physician, 3 per patient per day.	\$22.75

- H102A needs the full history, full exam, treatment and repeated attendance over many hours. A detailed exam of more than one system without that is H103A (A15).
- Re-assessment pays only 2+ hours after the last one, when more care is needed. Not for the discharge check, not when you admit the patient yourself, and not when it leads straight to a consult (A15).
- Only did a procedure in weekday daytime? Bill the procedure alone. The no-assessment premiums H112A–H114A are for evenings, weekends, holidays and nights (A16).
- Doing the admission assessment for an admitted patient? Tick C004A (\$38.35): it is paid on top of the H code and pays more than H105A interim orders (GP42).
- 10+ minutes on the phone getting a consultant's advice? Add K734A (\$37.05) on top of your assessment. Not when the call is to transfer care, book a consult or test, or mainly to discuss results (A42–A43).

Mon–Thu evening

H133A	Detailed look at more than one system Detailed history and exam of more than one system, part or region.	\$61.50
H132A	Full workup, treated and followed over hours Full history, full exam, treatment, and coming back to the patient over many hours.	\$75.40
H131A	Minor problem Brief history and exam of one area.	\$30.05
H134A	Re-assessment, 2+ hours later At least 2 hours after your last assessment, more care or tests needed. Limit: 2 per physician, 3 per patient per day.	\$30.05
H114A	Procedure only, no assessment billable Premium once per patient visit when you did a procedure or other service but can't claim an assessment. Tick the procedure below.	\$23.65

- Evening rates run Monday to Thursday 17:00–24:00. Friday evening pays the weekend rate: pick that tile (A16).
- A comprehensive assessment now pays \$75.40, \$18.70 more than in the daytime (A16).
- Non-elective procedure in this period? Tick E412A: OHIP adds 20% of the procedure fee (GP104). E409A/E410A are not for ED physicians on H codes.
- Did a procedure but can't claim an assessment (for example a planned recheck)? Bill H114A (\$23.65) once per visit with it (A16).

Fri evening, weekend or holiday

H153A	Detailed look at more than one system Detailed history and exam of more than one system, part or region.	\$69.60
H152A	Full workup, treated and followed over hours Full history, full exam, treatment, and coming back to the patient over many hours.	\$85.70
H151A	Minor problem Brief history and exam of one area.	\$34.15
H154A	Re-assessment, 2+ hours later At least 2 hours after your last assessment, more care or tests needed. Limit: 2 per physician, 3 per patient per day.	\$34.15
H113A	Procedure only, no assessment billable Premium once per patient visit when you did a procedure or other service but can't claim an assessment.	\$32.20

- For H codes every day from December 25 to 31 is a holiday, plus Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving and New Year's Day (GP3).
- Christmas on a weekend: the Friday before also counts. New Year's Day on a weekend: the Monday after. Canada Day on a weekend: your pick of the Friday before or the Monday after (GP3).
- Friday 17:00–24:00 already pays the weekend rate (A16).
- Non-elective procedure? Tick E412A for +20% of the procedure fee (GP104).

Night, any day

H123A	Detailed look at more than one system Detailed history and exam of more than one system, part or region.	\$80.95
H122A	Full workup, treated and followed over hours Full history, full exam, treatment, and coming back to the patient over many hours.	\$99.60
H121A	Minor problem Brief history and exam of one area.	\$39.85
H124A	Re-assessment, 2+ hours later At least 2 hours after your last assessment, more care or tests needed. Limit: 2 per physician, 3 per patient per day.	\$39.80
H112A	Procedure only, no assessment billable Premium once per patient visit when you did a procedure or other service but can't claim an assessment.	\$50.95

- Night rates apply 00:00–08:00 every day, weekends included, and pay the most: H122A is \$99.60 (A16).
- Non-elective procedure between 00:00 and 07:00? Tick E413A for +40% of the procedure fee (GP104). 07:00–08:00 gets E412A only on weekends and holidays.
- Procedure only, no assessment billable? H112A (\$50.95) goes with it once per visit (A16).

Consultation in the ED

H055A	Specialist in emergency medicine (FRCPC) Written request from another physician or NP; your ED record is the report and a copy must go to them.	\$125.65
H065A	Any other physician on ED duty Same requirements as H055A.	\$95.60

- Referred by another ED physician of the same hospital, or seen outside the ED or a critical care area? OHIP pays it as an assessment (GP19).
- No copy of the ED record to the physician or NP who referred: paid as an assessment (GP19).
- H055A pays \$125.65, more than any H assessment. When a physician outside your ED asked in writing for your opinion (a family doctor's letter, for example), bill the consult (GP16, GP19).
- Same diagnosis, same patient: one consult per 2 years, except a second in-patient or ED consult 12–24 months after the first (GP17).
- E078A (chronic disease premium) isn't payable to emergency medicine (12): 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.

Critical care or resuscitation

G521A	Life-threatening: first 15 min Vital organ system failure (shock, respiratory, CNS, renal, hepatic or metabolic failure) with imminent risk of death.	\$125.10
G521A + G523A	Life-threatening: 16–30 min First and second quarter hour. Add each further 15 min below.	\$189.60
G395A	Other critical care: first 15 min Resuscitation for a threat to life or limb that would otherwise need life-threatening critical care or cost the limb.	\$64.70

- Chart start and stop times or nothing is paid. Time counts only at the bedside, in the ED or on the patient's floor, fully devoted to that patient (J26–J27).
- Included, so don't bill them the same day: IV and central lines, arterial lines, intubation, blood gases, NG tube, urinary catheter, drugs given, and (life-threatening care only) defibrillation and cardioversion (J26, J28). Other procedures (chest tube, thoracentesis, LP, fracture care) are billed on top, and their time doesn't count as critical care time (J26, J28).
- An assessment before or after the critical care can still be billed (J27, J28). Don't count assessment time inside the critical care time. No assessment billed for this visit, in the evening, weekend, holiday or night? Add H114A, H113A or H112A (A16 note 4).
- Only the first 3 physicians get G521A/G523A/G522A; the 4th and later bill G391A per 15 min (J26). G395A and G521A can't both be billed the same day (J28).
- Over 2 hours in total? Submit for manual review (J29). Trauma with ISS over 15 (12 under age 16): E420A adds 50% (GP109).

Called in from home

A007A	Intermediate assessment History and exam of the affected part or system.	\$44.55
A003A	General assessment Full history and exam of every system.	\$95.60
A004A	General re-assessment Seen before for this; history may be shorter.	\$39.35
A001A	Minor assessment Brief history and exam of one area.	\$26.80

- Use this when you were not on shift and the ED asked you to come in (on a day you work there, or on scheduled ED call), and you were not already at the hospital (GP67).
- Called in, you bill A codes plus the ED-physician premiums (Table V), never H codes, and never the Table I K990A–K999A premiums (GP65, GP67).
- At night A007A with travel and first-person premiums pays \$184.75, nearly double an on-shift H122A (\$99.60).
- Chart the time the ED asked you to come and the specific situation that needed you, or the premiums are not paid (GP69).
- Already at the hospital when asked? Bill the H code for the time instead. Called to a ward? A codes with the in-patient C premiums (GP68).

Delivery or newborn

H007A	Stayed at a delivery for a high-risk baby Constant attendance at the delivery of a baby expected to be at risk, by a physician who is not a paediatrician. Includes the newborn assessment. Not paid if you bill any other service at the time of the delivery (A13–A14).	\$61.65
H001A	Newborn care of a well baby Routine care of a well newborn in hospital or at home for the first 10 days: first full assessment, follow-up checks and instructions to the parents. Limit: 1 per baby; a second only after a transfer to another hospital (GP32–GP33).	\$71.15

- Visits not listed under Emergency Medicine are billed from the Family Practice listings, so H007A and H001A are yours to bill (A97).
- H007A already includes the newborn assessment and pays nothing if you bill another service at the delivery, so don't add an H assessment for the same attendance (A13–A14).
- H001A covers the whole routine stay of a well newborn (up to 10 days): one claim per baby, not one per check (GP32–GP33).

Also bill, if it's true

C004A	You also did the admission assessment Patient admitted (by you or another MRP) and you did the admission assessment separately: paid as C004A on top of the H code. Then H105A pays nil (GP42, A16).	\$38.35
H105A	Wrote interim admission orders Non-elective patient being admitted by another physician. Nil if you are also paid the admission assessment (A16).	\$29.05
K734A	Phoned a consultant for advice, 10+ min Payable on top of your assessment. Not to arrange transfer, a consult or a test, or mainly to discuss results. 1 per patient per day (A42–A43).	\$37.05
K736A	CritiCall call for advice or transfer Call arranged by CritiCall Ontario, on top of your assessment. Unlike K734A it can be about transferring the patient. Max 2 per patient per day (A45–A46).	\$37.05
K035A	Reported a medical condition to the MTO Mandatory report under the Highway Traffic Act. No same-day limit with visits. More than 1 per 12 months for the same patient: manual review (A59).	\$36.25
K034A	Phoned a listed reportable disease to the MOH You made the immediate phone report yourself, e.g. acute bacterial meningitis, invasive meningococcal disease, measles, food poisoning. 1 per disease per patient per 12 months (A60).	\$36.00
H114A	Mon–Thu evening 17–24, no assessment billed Premium once per patient visit when you bill critical care or a procedure but no assessment (A16 note 4).	\$23.65
H113A	Fri evening, weekend or holiday 08–24, no assessment billed Premium once per patient visit (A16 note 4).	\$32.20
H112A	Night 00–08, no assessment billed Premium once per patient visit (A16 note 4).	\$50.95
H100A	Bedside ultrasound for a life threat Suspected tamponade, cardiac standstill, traumatic intraperitoneal bleed, ruptured AAA or ruptured ectopic, no radiologist available. Image saved + written report. Max 2 per day (A17).	\$19.65
H264A	Pelvic exam with speculum	\$12.00
E420A	Major trauma (ISS over 15, or over 12 under age 16) +50% on the day of the trauma or within 24 h. ISS in the chart, same claim. Also applies to procedures and critical care (GP109).	+50%
E412A	Non-elective procedure, evening, weekend or holiday: +20% Adds 20% to each eligible procedure fee: non-elective surgical procedures (fractures and dislocations too), deliveries and the major invasive G codes listed in GP104. Not injections, joint injections, assessments or critical care. OHIP computes it; the total here leaves it out (GP104).	
E413A	Non-elective procedure, 00:00–07:00: +40% Adds 40% to each eligible procedure fee: non-elective surgical procedures (fractures and dislocations too), deliveries and the major invasive G codes listed in GP104. Not injections or joint injections. OHIP computes it; the total here leaves it out (GP104).	
G522A	Each further 15 min of life-threatening care After the first 30 min, per quarter hour or part (J26).	\$42.50
G391A	Each further 15 min of other critical care After the first 15 min, per quarter hour or part (J28).	\$34.35
H960A + H980A	Weekday 07–17: travel + first patient Max 2 trips and 5 patients per period (GP74).	\$57.95
H962A + H984A	Weekday evening 17–24: travel + first patient Max 2 trips and 5 patients per period (GP74).	\$99.10
H963A + H988A	Sat, Sun or holiday 07–24: travel + first patient Max 4 trips and 10 patients per period (GP74).	\$114.50
H964A + H986A	Night 00–07: travel + first patient No maximum (GP74).	\$140.20
H981A	Weekday 07–17: another patient, same trip Counts toward the 5-patient maximum (GP74).	\$20.55

H985A	Weekday evening: another patient, same trip Counts toward the 5-patient maximum (GP74).	\$61.70
H989A	Weekend or holiday: another patient, same trip Counts toward the 10-patient maximum (GP74).	\$77.10
H987A	Night: another patient, same trip No maximum (GP74).	\$102.80

Did a procedure?

Z176A	Stitches, cut up to 5 cm Glue only: 50% of the fee (M15).	\$21.90
Z154A	Stitches up to 5 cm on the face, in layers or tying bleeders	\$39.35
Z175A	Stitches, cut 5.1–10 cm	\$39.35
Z177A	Stitches 5.1–10 cm on the face, in layers or tying bleeders	\$78.15
Z179A	Stitches, cut 10.1–15 cm Face or layered: Z190A (\$111.20).	\$55.20
Z187A	Complex face repair, 20+ min Lining up vermillion, eyebrow, eyelid or ear, or 3+ layers, or tying several bleeders (M15).	\$101.15
Z188A	Complex repair elsewhere, 20+ min 3+ layers or tying several bleeders; not a zone 1 fingertip (M15).	\$101.15
Z176A	Glue only, cut up to 5 cm Tissue adhesive pays 50% of the stitch fee (M15).	\$10.95
Z189A	Fingertip (zone 1) complex repair, 20+ min Per digit, no soft tissue loss. Includes foreign body removal, irrigation and debridement; no other repair code for the same injury. Time in the chart (M16).	\$101.15
Z101A	Draining an abscess, local Two: Z173A (\$33.25). Three or more: Z174A (\$44.70). Perianal: Z104A (\$33.25). Palm or sole: Z103A (\$48.60). Pilonidal or ischiorectal: Z106A (\$48.60). Bartholin: Z714A (\$25.40) (M1, V2).	\$28.20
Z510A	Draining a peritonsillar or pharyngeal abscess Oral abscess: Z506A (\$50.90) (S1).	\$91.10
Z114A	Removing a foreign body from skin Not with a complex repair Z187A/Z188A/Z189A of the same wound (M16).	\$27.65
Z847A	Removing an embedded corneal foreign body Two: Z848A (\$45.00). Three or more: Z845A, by independent consideration (Y2).	\$33.00
Z915A	Removing a foreign body from the ear canal Removing wax only pays nil (Y14).	\$10.55
Z311A	Removing a foreign body from the nose (P1).	\$10.55
Z314A	Nosebleed cautery	\$11.50
Z315A	Nosebleed, anterior packing Per side.	\$15.35
Z316A	Nosebleed, posterior packing	\$35.50
Z545A	Thrombosed haemorrhoid	\$25.25
Z128A	Nail removal needing anaesthetic More than one nail: Z129A (\$39.20) instead (M23).	\$36.30
Z611A	Bladder catheter, done yourself Only for acute retention, a Foley or suprapubic tube change, or instilling medication. Not with a surgical procedure. Included in critical care (T8, J26).	\$9.15
G211A	Intubation for resuscitation Included in critical care G521A/G395A (J26, J28).	\$38.35
Z437A	Cardioversion, electrical or chemical Max 3 sessions per day. Included in life-threatening critical care (J9, J26).	\$92.45
G269A	Central line Included in critical care (J26).	\$31.25
G268A	Arterial line Included in critical care (J26).	\$31.25
Z341A	Chest tube	\$76.80

Z332A	Thoracentesis Diagnostic or therapeutic.	\$104.40
Z591A	Paracentesis with drainage Diagnostic sample only: Z590A (\$31.30).	\$57.65
Z804A	Lumbar puncture Includes image guidance (J83).	\$150.00
G372A	IM or SC injection given with the assessment Each injection, e.g. tetanus immune globulin, IM analgesic or antiemetic. Included in critical care (J54, J26).	\$4.55
G847A	Tetanus shot: Tdap Paid on top of the assessment (J3, J54).	\$8.80
G538A	Tetanus shot: Td or another vaccine with no own code Paid on top of the assessment (J3, J54).	\$8.80
G370A	Joint aspiration or injection Each extra joint G371A (\$19.90).	\$20.25
G060A	Femoral or fascia iliaca block for acute pain (e.g. hip fracture) Major peripheral nerve block lasting over 4 h, max 4 a day. Not paid as the anaesthetic for your own procedure (J70–J71).	\$55.00
D015A	Shoulder dislocation, reduced without anaesthetic With anaesthetic: D016A (\$111.40). Sent elsewhere for after-care: claim 75% (N2).	\$49.20
D012A	Pulled elbow reduced	\$39.00
D009A	Elbow dislocation, closed reduction Sent elsewhere for after-care: claim 75% (N2, N20).	\$84.45
D001A	Finger dislocation, closed reduction Each more finger E576A (\$10.25). MCP joint: D004A (\$57.50), each more E577A. Sent elsewhere for after-care: claim 75% (N2, N15).	\$57.50
F005A	Finger fracture, closed reduction Each more E558A (\$22.25). No reduction, molded splint or cast you apply: F004A (\$49.20); a metal splint is visit only (N1, N14).	\$99.25
F009A	Metacarpal fracture, closed reduction Each more E504A (\$22.20). Rigid immobilization only: F008A (\$49.20) (N14).	\$99.25
F028A	Distal radius fracture, closed reduction under local Cast included. Sent to fracture clinic for after-care: claim 75%. A second fracture or dislocation the same day pays 85% (N1, N2).	\$109.45
D040A	Kneecap dislocation, reduced without anaesthetic With anaesthetic: D031A (\$97.35) (N49).	\$62.20
D042A	Hip dislocation, closed reduction Sent elsewhere for after-care: claim 75% (N2, N39).	\$268.25
Z203A	Arm, forearm or wrist cast or corrective splint Not within 2 weeks of a fracture you bill a procedure fee for. Splinting in the ED is paid as the visit plus a cast if one is applied (N2, N7).	\$24.10

Can I bill these together?

Code	With	Together ?	Why
H101A,H102A,H103A, H104A,H131A,H132A, H133A,H134A, H151A,H152A,H153A, H154A,H121A,H122A, H123A,H124A,H051A, H065A,A007A,A008A, A009A,A004A, A001A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A, Z101A, Z173A, Z174A, Z104A, Z103A, Z106A, Z714A, Z510A, Z506A, Z114A, Z847A, Z848A, Z915A, Z311A, Z314A, Z315A, Z316A, Z545A, Z128A, Z129A, Z611A, Z437A, Z341A, Z332A, Z590A, Z591A, Z804A, Z401A, Z180A, Z608A, Z080A, R024A, D015A, D016A, D012A, D009A, D001A, D004A, D007A, D014A, D040A, D031A, D042A, D035A, D062A, D027A, D030A, F004A, F005A, F006A, F008A, F009A, F018A, F102A, F027A, F028A, F046A, F031A, F032A, F024A, F025A, F054A, F110A, F136A, F074A, F075A, F078A, F082A, F083A, F061A, F062A, F063A, F070A, F066A, F056A, F058A, Z203A, Z213A, Z201A, Z202A, Z199A, Z198A, Z211A, Z204A	Yes	The assessment where you decide to treat is paid on top: Z-code procedures are paid in addition to an assessment (GP4), fracture and dislocation care in addition to the assessment before it (N1), and called in, the A-code assessment plus the procedure (SP2). A planned return only for the procedure gets no assessment; in premium hours bill H112A–H114A instead (A16).

Code	With	Together ?	Why
H112A,H113A,H114A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A, Z101A, Z173A, Z174A, Z104A, Z103A, Z106A, Z714A, Z510A, Z506A, Z114A, Z847A, Z848A, Z915A, Z311A, Z314A, Z315A, Z316A, Z545A, Z128A, Z129A, Z611A, Z437A, Z341A, Z332A, Z590A, Z591A, Z804A, Z401A, Z180A, Z608A, Z080A, R024A, D015A, D016A, D012A, D009A, D001A, D004A, D007A, D014A, D040A, D031A, D042A, D035A, D062A, D027A, D030A, F004A, F005A, F006A, F008A, F009A, F018A, F102A, F027A, F028A, F046A, F031A, F032A, F024A, F025A, F054A, F110A, F136A, F074A, F075A, F078A, F082A, F083A, F061A, F062A, F063A, F070A, F066A, F056A, F058A, Z203A, Z213A, Z201A, Z202A, Z199A, Z198A, Z211A, Z204A, G521A, G523A, G522A, G395A, G391A, G211A, G268A, G269A, G303A, G370A, G371A, G060A, G270A, G356A, G380A, Z459A, G372A, G538A, G847A, H100A, H264A	Yes	When you render any other service in premium hours and can't claim an assessment, one of H112A, H113A or H114A is paid per patient visit on top of it (A16 note 4).
H264A	H101A, H102A, H103A, H104A, H131A, H132A, H133A, H134A, H151A, H152A, H153A, H154A, H121A, H122A, H123A, H124A, H055A, H065A	Yes	H264A is paid in addition to an assessment; 1 per patient per day, done by you (A18).
H100A	H101A, H102A, H103A, H104A, H131A, H132A, H133A, H134A, H151A, H152A, H153A, H154A, H121A, H122A, H123A, H124A, H055A, H065A	Yes	H100A is a procedure with its own limit (2 per patient per day); A17 doesn't restrict it with an assessment. Only for the listed life threats, with saved images and a report (A17).
C004A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A	Yes	When your ED visit wasn't a consultation, general assessment or general re-assessment and you then do the admission assessment separately, it is paid as C004A on top, even if another physician is MRP (GP42).
C004A	H055A, H065A	No	When your ED service was a consultation, it already is the admission assessment: no C004A on top (GP42).

Code	With	Together ?	Why
G521A,G523A,G522A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A, Z101A, Z173A, Z174A, Z104A, Z103A, Z106A, Z714A, Z510A, Z506A, Z114A, Z847A, Z848A, Z915A, Z311A, Z314A, Z315A, Z316A, Z545A, Z128A, Z129A, Z341A, Z332A, Z590A, Z591A, Z804A, Z401A, Z180A, Z608A, Z080A, R024A, D015A, D016A, D012A, D009A, D001A, D004A, D007A, D014A, D040A, D031A, D042A, D035A, D062A, D027A, D030A, F004A, F005A, F006A, F008A, F009A, F018A, F102A, F027A, F028A, F046A, F031A, F032A, F024A, F025A, F054A, F110A, F136A, F074A, F075A, F078A, F082A, F083A, F061A, F062A, F063A, F070A, F066A, F056A, F058A, Z203A, Z213A, Z201A, Z202A, Z199A, Z198A, Z211A, Z204A, G303A, G060A, G270A	Yes	Procedures not on the included list are paid on top of life-threatening critical care; their time is left out of the critical care time (J26 rule 1).

Code	With	Together ?	Why
G395A,G391A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A, Z101A, Z173A, Z174A, Z104A, Z103A, Z106A, Z714A, Z510A, Z506A, Z114A, Z847A, Z848A, Z915A, Z311A, Z314A, Z315A, Z316A, Z545A, Z128A, Z129A, Z437A, Z341A, Z332A, Z590A, Z591A, Z804A, Z401A, Z180A, Z608A, Z080A, R024A, D015A, D016A, D012A, D009A, D001A, D004A, D007A, D014A, D040A, D031A, D042A, D035A, D062A, D027A, D030A, F004A, F005A, F006A, F008A, F009A, F018A, F102A, F027A, F028A, F046A, F031A, F032A, F024A, F025A, F054A, F110A, F136A, F074A, F075A, F078A, F082A, F083A, F061A, F062A, F063A, F070A, F066A, F056A, F058A, Z203A, Z213A, Z201A, Z202A, Z199A, Z198A, Z211A, Z204A, G303A, G060A, G270A	Yes	Procedures not on the included list, cardioversion included, are paid on top of other critical care; their time is left out of the critical care time (J28 rule 2).
G372A	G521A, G523A, G522A, G395A, G391A	No	Drugs given during critical care are included in it (J26 item 11, J28 item 11).
E078A	H055A, H065A	No	E078A is only paid to the specialties listed in GP25; Emergency Medicine (12) isn't one of them (GP25).
H104A,H134A,H154A, H124A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, H055A, H065A	Sometimes	Only 2+ hours after the earlier assessment, when more care is needed; not at discharge, not if you admit, not if it leads to a consult. Max 2 per physician per patient per day (A15).
H112A,H113A,H114A	H101A, H102A, H103A, H104A, H131A, H132A, H133A, H134A, H151A, H152A, H153A, H154A, H121A, H122A, H123A, H124A, H055A, H065A	No	The no-assessment premium is only for visits where an assessment can't be claimed (A16 note 4).
H105A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, H055A, H065A	Yes	Interim admission orders are payable on top of your initial consultation or assessment (A16). Nil if you are paid the admission assessment.
H105A	C004A	No	H105A pays nil when you are paid the admission assessment; C004A pays more (A16, GP42).
H104A,H134A,H154A, H124A	C004A	No	Re-assessment is not payable when the ED physician admits the patient (A15).
H055A	H065A	No	H055A is for FRCPC emergency medicine specialists, H065A for everyone else; one consult (GP19).

Code	With	Together ?	Why
K734A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, H104A, H134A, H154A, H124A	Yes	The referring physician's phone consult fee is payable in addition to visits the same day (A42). 10+ min, not to arrange a transfer, consult or test (A43).
K734A	K730A	No	On ED duty use K734A, not K730A; one per patient per day (A43).
G521A,G523A,G522A	G395A	No	G395A is not payable with G521A, G522A or G523A the same day (J28).
G521A,G523A,G522A	G211A, Z437A, G268A, G269A, Z611A, G380A, G356A, Z459A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters, defibrillation and cardioversion are included in life-threatening critical care (J26).
G395A,G391A	G211A, G268A, G269A, Z611A, G380A, G356A, Z459A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage and catheters are included in other critical care (J28).
G060A,G061A,G260A,G231A,G223A,G243A,G244A,G214A	D015A, D016A, D012A, D009A, D001A, D004A, F005A, F009A, F028A, F075A, D040A, D031A, D042A, Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z187A, Z188A, Z189A, Z128A, Z129A, Z101A, Z114A	No	A nerve block you give for your own procedure isn't paid; a block lasting over 4 hours for pain after it is billed as G224A (\$15.55) instead (J70, J79).
Z187A,Z188A,Z189A	Z114A, Z128A, Z129A, Z080A, Z081A, Z084A	No	Complex repairs include foreign body removal, irrigation and debridement; Z114A, Z128A, Z129A and wound debridement aren't paid with them for the same repair (M16).
Z080A,Z081A,Z082A,Z083A,Z084A,Z085A	Z154A, Z175A, Z176A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A	No	Wound debridement isn't paid with laceration repair (M10).
Z611A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z187A, Z188A, Z101A, Z341A, Z591A, D015A, D016A, F028A, D042A	No	Bladder catheterization isn't paid in conjunction with any surgical procedure (T8).
H007A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, G521A, G395A	Sometimes	H007A isn't paid if you bill any other service at the time of the delivery; an assessment at another time is separate (A14).
G521A,G395A	H101A, H102A, H103A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, H055A, H065A	Sometimes	An assessment or consult before or after the critical care is payable; ongoing monitoring during it is not, and its time can't be counted twice (J26–J28).
H960A,H962A,H963A,H964A,H980A,H981A,H984A,H985A,H988A,H989A,H986A,H987A	H101A, H102A, H103A, H104A, H131A, H132A, H133A, H151A, H152A, H153A, H121A, H122A, H123A, H055A, H065A	No	Special visit premiums are never paid with H codes; when called in, bill A codes (GP65, GP69).

Code	With	Together ?	Why
K990A,K992A,K994A,K996A,K998A	H101A, H102A, H103A, H121A, H122A, H123A, H131A, H132A, H133A, H151A, H152A, H153A, A007A, A003A	No	Table I ED premiums are not paid to ED physicians; called in, use Table V H960A–H989A (GP67).
E412A,E413A	E409A, E410A	No	ED physicians on H codes get E412A/E413A; E409A/E410A are not payable to them (GP104).
E412A	E413A	No	One after-hours rate per procedure: E412A evenings/weekend days, E413A nights (GP104).
F028A	Z203A	No	Casts in the first 2 weeks after a fracture with a procedural fee are included (N7).
H100A	J149	Yes	J149 ultrasound guidance and H100A are the only ultrasound services an ED physician can bill (A16 note 3).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (A13–A17, A42–A43, A97, GP3, GP19, GP32–GP33, GP50, GP64–GP74, GP104, GP109, J7, J26–J29, J70–J81, M1, M10, M15–M16, M23, N1–N59, P1, S1, T8, V2, Y2, Y14). With more than one fracture or dislocation, the major one is paid in full and each other at 85% (N1). H codes apply to any physician on an ED or hospital urgent care clinic shift, and to on-call physicians whose visit doesn't qualify for a special visit premium (GP50). The total leaves out the 15% age premium OHIP adds for patients 65+ on H102A/H103A-type codes (GP64), the under-16 premiums on procedures, and E412A/E413A after-hours procedure premiums. In an ED funded by an alternative funding agreement, these services are not billed fee-for-service (GP110).

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