

Gastroenterology OHIP Billing Cheat Sheet 2026

OHIP specialty 41 · Colonoscopy · Gastroscopy (upper scope) · ERCP or EUS · Updated October 2026

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

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

Colonoscopy

Z496A	Symptoms or signs Bleeding, anaemia, change in bowel habit, pain and other symptoms.	\$51.95
Z497A	Positive FIT, sigmoidoscopy, barium enema or CT Confirmatory colonoscopy after a positive screening test.	\$51.95
Z498A	Surveillance after polyps or cancer At the interval in the Ontario post-polypectomy guidelines.	\$51.95
Z494A	IBD, FAP, Lynch or other high-risk bowel disorder At guideline age and interval.	\$51.95
Z499A	No symptoms, family history of colorectal cancer At guideline age.	\$51.95
Z555A	No symptoms or risk factors, age 50+ Uninsured within 10 years of the last Z555A. Limit: 1 per 10 years.	\$51.95

- Reached the cecum? Add E740A + E741A + E747A for the extent: a full colonoscopy pays \$166.00, not \$51.95 (S18).
- Only one of Z491A–Z499A or Z555A per patient per day. Other reasons: Z495A after a technically unsatisfactory scope, Z491A to finish an incomplete polyp resection within 6 months, Z492A/Z493A for follow-up of a normal scope (S16–S17).
- Polyps: bill the largest one as the first-polyp code (\$150.15), then up to 2 more at \$77.50 each. Polyps under 3 mm aren't paid. Fulguration is included (S19).
- Decision visit (by anyone) in the last 12 months? The only assessment payable on scope day is A120A (\$18.85). If today's consult is the decision visit, bill the consult instead and nothing else before the scope (A104, SP4).
- Colonoscopy for constipation alone is insured only at 50+, with a family history, or with alarm features (S18).

Gastroscopy (upper scope)

Z399A	Oesophagus, stomach ± duodenum, elective The usual EGD.	\$92.50
Z400A	Same, for active bleeding	\$125.10
Z515A	Oesophagoscopy only With or without biopsies.	\$68.25
Z527A	Gastroscopy May include biopsies, photos and polyps up to 1 cm.	\$82.90
Z528A	Repeat gastroscopy within 3 months Within three months of the previous gastroscopy.	\$67.85
Z547A	Gastroscopy with foreign body removal	\$99.75

- A standard EGD is Z399A (\$92.50); for active bleeding Z400A pays \$125.10 (S7).
- Doing the colonoscopy in the same session? Tick it below: both scopes are paid in full (SP4 §13).
- 3+ biopsies of one specific lesion: add E702A (\$15.10). Bleeding treated: E797A (\$46.30), or E798A (\$69.70) if the patient is unstable and actively bleeding (S7).
- Snare polypectomy over 1 cm: E703A then E799A for up to 2 more with Z399A; with Z527A, Z528A or Z547A use E674A (\$142.40), then E675A (\$73.50 each, up to 2) (S7, S11).
- Decided on the scope at your earlier visit (last 12 months)? A partial assessment A418A (\$44.75) is still payable before it today, and is the only one allowed (SP4 §13). Duodenoscopy Z560A isn't payable within 3 months of a Z399A or Z400A (S15).

ERCP or EUS

Z558A	ERCP with sphincterotomy May include removing one or more duct stones.	\$300.25
Z561A	ERCP, cannulation only Common bile duct and/or pancreatic duct.	\$213.15
Z760A	ERCP through a Billroth II gastrojejunostomy	\$251.85
S237A	EUS with biliary or pancreatic exam Linear or radial echo-endoscope.	\$253.80
S236A	EUS without biliary or pancreatic exam	\$203.05

- Z558A (\$300.25) covers the sphincterotomy and stone removal; Z561A (\$213.15) is cannulation only (S30).
- Also looked at oesophagus, stomach and duodenum? Add E669A (\$102.75). Stents: E680A for the first (\$82.35), E681A for each extra, up to 3 (S30).
- E816A lithotripsy only for confirmed duct stones that failed standard extraction (S30).
- An upper or lower scope with EUS pays \$0 unless it was needed because the echo-endoscope's view was limited. S236A with S237A pays \$0 (S6).
- EUS-guided biopsy or FNA: E802A per lesion, up to 3 (S6).

Office consultation

A415A	Consultation Written referral from a physician or NP; written report back.	\$159.45
A416A	Repeat consultation Same problem, after another physician cared for the patient in between; new written referral.	\$106.90
A545A	Limited consultation Consult that needed much less time than a full one.	\$106.90

- Without a written, signed referral, or without a written report back, it is paid as an assessment (GP16).
- Same diagnosis: 1 consult per 2 years. A clearly unrelated diagnosis allows one per 12 months (GP17).
- Patient back after another doctor treated them in between, with a new referral? Repeat consult A416A (\$106.90) pays more than A414A (\$72.00) (GP19).
- Consult and colonoscopy the same day? The consult is payable only if it is the visit where you decided to scope; then A120A can't be added (A104, SP4).
- Under 16: OHIP adds 10–30% to consults on the remittance (GP64).

Office follow-up

A414A	Re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months.	\$72.00
A411A	Complex re-assessment, report to family doctor Complex, obscure or serious condition. Written findings to the primary care physician. Limit: 4 per 12 months.	\$83.40
A413A	Full specific assessment Full history of the complaint and detailed exam of the affected systems. Limit: 1 per 12 months (2 if a new diagnosis).	\$95.95
A418A	Partial assessment History of the complaint, needed exam, advice.	\$44.75

- Complex case? A411A pays \$83.40, more than A414A (\$72.00), when you send your findings in writing to the family doctor (GP24).
- A413A is 1 per patient per 12 months (2 for a clearly different diagnosis). A413A and A411A together are capped at 4 per 12 months; extras pay as a lesser assessment (GP23–24).
- Crohn's, ulcerative colitis, malnutrition, celiac or cirrhosis? Add E098A: +28% in the office or hospital clinic (not ED or in-patient). Diagnostic code 263, 555, 556, 571 or 579 (A104–A105).
- A411A + E098A pays \$106.75, more than A413A (\$95.95) for an established IBD or cirrhosis patient.
- E078A (chronic disease premium) isn't payable to gastroenterology (41): 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 Crohn's, colitis, celiac, cirrhosis or malnutrition, tick E098A instead: +28% (A104–A105).

ED consult

A415A	Consultation Written request from the ED physician.	\$159.45
A416A	Repeat consultation Same problem, new request, another physician cared in between.	\$106.90
A545A	Limited consultation	\$106.90
A413A	Specific assessment No referral, or your own patient.	\$95.95

- Not on ED duty, seeing a patient in the ED or out-patient department: bill the A codes, not C codes (A105).
- Called in from outside the hospital, or after hours? Set it in the header: the special visit premiums are added for you. Chart the time you saw the patient (GP65, GP69).
- Admitting the patient? This consult is the admission assessment. As MRP add E082A (+30%), once per admission (GP40, GP42).
- A second consult for the same diagnosis 12–24 months after the first is allowed when it is an ED or in-patient consult (GP17).
- Scoped them after 17:00, on a weekend or a holiday? Tick the scope below and add E409A or E410A on the procedure fee, on top of the consult and special visit premiums (SP2 \$2, GP104).

In-patient consult

C415A	Consultation, routine Requested consult seen as part of your hospital day.	\$159.45
A415A	Consultation, called in urgently Non-elective call to the ward; in-patient premiums apply.	\$159.45
C545A	Limited consultation	\$106.90
C416A	Repeat consultation	\$106.90
C413A	Specific assessment Admission assessment of your own patient.	\$95.95
C411A	Complex re-assessment Report in writing to the primary care physician.	\$83.40

- Urgent call to an in-patient (not on rounds)? Use the A415A option: same fee, plus the in-patient special visit premiums (A105, GP72).
- Admitting as MRP: add E082A (+30%) to the admission assessment, once per admission; not if the hospital pays you for in-patient work without reducing it (GP42).
- One consult or admission assessment per admission, even if the patient moves between physicians (GP40).

Hospital rounds

C412A	Subsequent visit, weeks 1–5	\$40.05
C122A	MRP visit, day after admission 1 per admission.	\$71.80
C123A	MRP visit, second day after admission 1 per admission.	\$71.80
C124A	MRP visit, discharge day Stay 48 h+; discharge summary within 48 h and follow-up arranged.	\$71.80
C126A	MRP discharge, complex patient Stay 7+ days, 3+ diagnoses, 45+ min.	\$95.10
C417A	Subsequent visit, weeks 6–13 Limit: 3 per week.	\$40.05
C142A	MRP visit, first after transfer out of ICU Patient had critical, ventilatory or comprehensive care in the ICU right before moving to a ward bed, and you didn't give that care. In place of C122A; not with C124A or C126A that day (GP46). Limit: 1 per admission.	\$71.80
C143A	MRP visit, second after transfer out of ICU Same conditions as C142A. In place of C123A (GP46). Limit: 1 per admission.	\$71.80
G254A	Liver transplant patient, first 2 weeks: immunosuppression Billed in place of the visit, 1 per day (J45).	\$39.50

- As MRP, C122A/C123A the two days after admission and C124A on discharge day pay \$71.80 instead of \$40.05 (GP44–45).
- MRP on a subsequent visit: add E083A (+30%), or E084A (+45%) on a Saturday, Sunday or holiday. One per patient per day; not if the hospital pays you for in-patient work without reducing it (GP47).

- After week 13: C419A, max 6 per month. Acute intercurrent illness after week 5: C121A, outside the limits. Concurrent care while the family doctor stays MRP: C418A (A106).
- Liver transplant patient in the first 2 weeks: G254A (\$39.50) in place of the visit, 1 per day (J45).
- Took over from ICU as MRP? C142A and C143A pay \$71.80 for the first two ward visits, but not if you gave the ICU care or the patient was there only for monitoring. Palliative care visits as MRP: C982A (\$40.05), which also takes E083A/E084A (GP46–GP47, GP50).

Phone or video

A414A + K300A	Video follow-up, known patient Seen in person in the last 24 months, or in a video consult relationship. Full fee.	\$72.00
A414A + K301A	Phone follow-up, known patient Phone pays 85% of the in-person fee.	\$72.00
A411A + K301A	Phone complex re-assessment 85% of A411A. Written report to the family doctor.	\$83.40
A415A + K300A	Consultation by video Consults are video only, never phone.	\$159.45
A101A	Video, new to you, no relationship Limited virtual care.	\$20.00
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit or transfer, or mainly about results. Not paid if you see the patient that day or the next (A42–A43).	\$47.75
K739A	e-Consult reply Opinion through a secure server within 30 days. Max 1 a day and 6 per patient per 12 months. Not paid if you see the patient that day or the next (A48–A49).	\$20.50

- The patient (or the referral) has to start the contact; a check-in call you start isn't billable (A68).
- Consults and in-patient C codes are video only. A follow-up by phone pays 85% (A70, Appendix J).
- Write the modality in the chart. If an exam turns out to be needed, only the in-person visit is paid (A68).
- Advised another doctor by phone (K731A, \$47.75) or answered an e-consult (K739A, \$20.50)? Not paid if you see the patient yourself that day or the next (A43, A49).

Also bill, if it's true

E740A + E741A + E747A	Reached the cecum Splenic + hepatic flexure + cecum add-ons.	\$114.05
E740A + E741A	Reached the hepatic flexure	\$82.90
E740A	Reached the splenic flexure	\$51.75
E705A	Intubated the terminal ileum	\$30.30
Z571A	Removed a polyp, largest 3–5 mm Bill the largest polyp here; 1 per day (S19).	\$150.15
Z518A	Removed a polyp, largest 6–9 mm 1 per day (S19).	\$150.15
Z517A	Removed a polyp, largest 10–19 mm 1 per day (S19).	\$150.15
Z516A	Removed a polyp, largest 20–29 mm 1 per day (S19).	\$150.15
E720A	Each more polyp 3–5 mm Max 2 more polyps of any size per day (S19).	\$77.50
E520A	Each more polyp 6–9 mm Max 2 more of any size per day (S19).	\$77.50
E519A	Each more polyp 10–19 mm Max 2 more of any size per day (S19).	\$77.50
E518A	Each more polyp 20–29 mm Max 2 more of any size per day (S19).	\$77.50
E685A	Removed a sessile polyp over 3 cm Total excision, each (S19).	\$227.65
E717A	Biopsies, or coagulated angiodysplasia One or more (S18).	\$27.05
E785A	IBD dysplasia surveillance biopsies Dx 555, 556 or 576; 35+ random sites or targeted with chromoendoscopy or HD. Not with E717A (S18–S19).	\$54.25
E797A	Treated bleeding (any technique) Uncomplicated bleeding; with Z496A or Z497A only for colonoscopy (S7, S18).	\$46.30
Z764A	Removed an obstructing tumour or stricture, under 2 cm Through the colonoscope (S19).	\$69.80
Z765A	Removed an obstructing tumour or stricture, 2 cm+ Through the colonoscope (S19).	\$131.75
E687A	Laser debulking of that tumour Add-on to Z764A or Z765A (S19).	\$69.80
E630A	Placed a colonic stent	\$137.05
E749A	Done in your private office Not in a hospital or ICHSC (S18–S19).	\$22.35
A120A	Saw the patient before the scope today Only when the decision visit was in the last 12 months (by any physician) and none is billed today (A104).	\$18.85
E702A	3+ biopsies of a specific lesion	\$15.10
E798A	Unstable patient, active bleeding treated Complicated upper GI bleed (S7).	\$69.70
E696A	Dilated the oesophagus	\$30.65
E698A	Pneumatic or balloon dilation	\$69.70
E690A	Removed a foreign body or stent	\$43.85
E703A	Snare polypectomy, first polyp over 1 cm	\$50.50

E799A	Each more snared polyp over 1 cm Max 2 (S7).	\$25.25
E674A	Snare polypectomy, first polyp over 1 cm With gastroscopy codes (S11).	\$142.40
E675A	Each more snared polyp over 1 cm After E674A. Max 2 (S11).	\$73.50
E795A	Brushings Oesophagus, stomach and/or duodenum.	\$46.30
E813A	Radiofrequency ablation of dysplastic Barrett's	\$215.00
E836A	EMR of a lesion over 3 cm Total excision.	\$227.65
E629A	Placed a duodenal stent	\$137.05
E692A	Laser debulking Extensive laser palliation of a fully obstructing oesophageal tumour is E695A, by independent consideration (S7).	\$69.70
E770A	Duodenal bile drainage after IV CCK (S7).	\$23.10
E800A	Radial or linear probe EUS through the scope Pays \$0 with E801A (S6).	\$101.50
E801A	Probe EUS including biliary or pancreatic exam	\$152.30
E680A	First biliary or pancreatic stent Max 1 (S30).	\$82.35
E681A	Each more stent Max 3 (S30).	\$43.60
E662A	Intraductal brushing or biopsy	\$49.75
E668A	Cannulated the minor papilla	\$93.80
E816A	Electrohydraulic lithotripsy Confirmed stones refractory to standard extraction (S30).	\$50.00
E669A	Also examined oesophagus, stomach ± duodenum	\$102.75
E702A	3+ biopsies of a specific lesion	\$15.10
E666A	Biliary manometry	\$52.30
Z593A	Placed a nasobiliary drain Separate listing, not one of the ERCP add-ons (S30).	\$55.25
E802A	EUS biopsy or FNA Max 3 per lesion (S6).	\$50.75
E803A	Dilated a stricture	\$30.65
E804A	Injection: celiac plexus, mass, node or metastasis	\$145.05
E805A	Drained a pseudocyst Includes a stent if placed (S6).	\$203.05
E098A	Crohn's, colitis, malnutrition, celiac or cirrhosis +28%. Office or hospital clinic, not ED or in-patient. Dx 263, 555, 556, 571 or 579 (A104–A105).	+28%
E098A	Crohn's, colitis, malnutrition, celiac or cirrhosis +28%, also payable on virtual follow-ups (A74). Dx 263, 555, 556, 571 or 579.	+28%
E082A	You admitted the patient as MRP +30% on the admission assessment, once per admission (GP42).	+30%
E083A	You are the MRP, weekday +30% (GP47).	+30%
E084A	You are the MRP, Saturday, Sunday or holiday +45% (GP47).	+45%

A418A	Saw the patient before the scope today Partial assessment. Only when you decided on the scope at an earlier visit in the last 12 months; it is the only assessment payable before the scope. If today's consult is the decision visit, bill the consult instead. On a colonoscopy day use A120A (SP4 §13, A104).	\$44.75
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of this scope and any procedure ticked below (SP2 §2, GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of this scope and any procedure ticked below (SP2 §2, GP104).	+75%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the consult (SP2 §2, GP104).	+50%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the consult (SP2 §2, GP104).	+75%
K036A	Filled in the Northern Health Travel Grant form Specialist's part of the form; payable to the referring doctor and the specialist (A60).	\$10.25
K070A	Home care referral form to Ontario Health atHome You're the MRP giving ongoing care (e.g. paracentesis or tube care at home). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K070A	Home care referral form at discharge You're the MRP and will keep caring for the patient. Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K730A	Phoned another specialist for advice about this patient You're the referring doctor and keep the patient's care; 10+ minutes, start and stop times charted. Not to arrange a referral, a transfer or to discuss test results. Paid on top of today's visit; 1 per patient per day (A42–A44).	\$37.05
K121A	In-patient case conference Per 10-minute unit (10, 16, 26, 36 min...). Pre-scheduled, with the MRP plus 2+ other physicians or regulated professionals; chart start/stop, participants and outcome. Paid with today's visit, as long as the visit was done outside the conference. Max 4 per patient per 12 months, 8 units a day (A31–A33).	\$37.05

Another scope or procedure?

Z399A	Gastroscopy (EGD) in the same session Both scopes paid in full (SP4).	\$92.50
Z496A + E740A + E741A + E747A	Colonoscopy to cecum in the same session Swap Z496A for the right reason code.	\$166.00
Z580A	Flexible sigmoidoscopy Not with a colonoscopy the same day (S15).	\$57.70
Z535A	Rigid sigmoidoscopy With biopsy Z536A (\$44.55). Outside hospital add E746A (\$5.85).	\$36.80
Z592A	Sigmoidoscopy with volvulus decompression Outside hospital add E746A (\$5.85) (S25).	\$49.40
E641A	Rectal stent through the sigmoidoscope Add-on to the sigmoidoscopy code (S25).	\$137.05
Z512A	Scope of an ileostomy or colostomy Also reducing an obstructed Kock ileostomy (S15).	\$36.80
Z514A	Stoma scope with biopsy Instead of Z512A (S15).	\$44.55
Z543A	Anoscopy Included in haemorrhoid banding or injection (S27).	\$8.70
Z546A	Haemorrhoid banding Max 6 a year (S28).	\$39.40
Z575A	Haemorrhoid injections Max 6 a year (S28).	\$27.05
Z545A	Thrombosed haemorrhoid Outside hospital add E542A (\$12.65).	\$25.25
Z576A	Anal fissure injection Cauterizing a fissure instead: Z548A (\$34.90) (S28).	\$35.90
Z756A	Fecal disimpaction, no anaesthetic Severe impaction refractory to conservative care, done personally (S27).	\$46.00
Z591A	Paracentesis with drainage Diagnostic only Z590A (\$31.30). Outside hospital add E542A.	\$57.65
Z551A	Liver biopsy, needle	\$95.80
Z532A	PEG insertion	\$172.95
Z520A	Changed a gastrostomy tube	\$10.65
Z513A	Colonic stricture dilation through the scope	\$107.50
Z584A	Push enteroscopy	\$185.15
G349A	Blakemore tube insertion	\$45.30
G350A	Oesophageal manometry, interpretation Professional fee.	\$97.85
G353A	Oesophageal provocation testing Only with acid perfusion, provocative drugs, multiple rapid swallows, rapid drink challenge or solid bolus swallows (J44).	\$35.00
G351A	24 h+ reflux monitoring, interpretation Professional fee.	\$51.50
G354A	Anorectal manometry, interpretation Professional fee.	\$61.80
G332A	Capsule endoscopy, reading Professional fee.	\$185.00
G166A	Hydrogen breath test, interpretation Professional component; technical G167A (\$7.70) if you run it.	\$10.45

G372A	Injection with the visit (e.g. B12, methotrexate) Each intramuscular or subcutaneous injection; paid on top of the assessment (J3, J54).	\$4.55
G483A	Therapeutic venisection (e.g. haemochromatosis) Paid on top of the assessment (J3, J7).	\$9.70

Can I bill these together?

Code	With	Together ?	Why
E078A	A411A, A413A, A414A, A418A	No	E078A is only paid to the specialties listed in GP25; Gastroenterology (41) isn't one of them (GP25).
A120A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A	Yes	A120A is the only assessment payable on colonoscopy day when the decision visit was in the prior 12 months (A104).
A120A	A415A, A416A, A545A, A413A, A414A, A411A, A418A	No	A120A is not payable when a decision (major pre-operative) visit is payable the same day, and it is the only assessment allowed otherwise (A104).
A413A,A414A,A411A,A418A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A	Sometimes	Only when this assessment is the visit where you decided to scope (major pre-operative visit, GP4) and no decision visit by any physician in the past 12 months; then nothing else before the scope. Otherwise A120A is the only assessment payable that day (A104, SP4 §13).
A415A,A545A,A416A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A, Z399A	Sometimes	Only when the consult is the visit where you decided to scope; then nothing else is payable before the scope (SP4 §13).
Z491A,Z492A,Z493A,Z494A,Z495A,Z496A,Z497A,Z498A,Z499A,Z555A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A	No	Only one colonoscopy reason code per patient per day (S17).
Z580A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A	No	Flexible sigmoidoscopy is not payable with a colonoscopy the same day (S15).
Z535A	Z555A, Z580A	No	Rigid sigmoidoscopy is not billed with Z555A or Z580A (S25).
Z571A,Z518A,Z517A,Z516A	Z571A, Z518A, Z517A, Z516A	No	Only one first-polyp code per day; bill the largest polyp (S19).
E717A	E785A	No	E717A with E785A is not payable (S18).
E797A	Z491A, Z492A, Z493A, Z494A, Z495A, Z498A, Z499A, Z555A	No	For colonoscopy, E797A adds only to Z496A or Z497A (S18).
E749A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A, Z512A, Z580A	Sometimes	Only when done in a private office, not a hospital or ICHSC (S18–S19).
Z399A,Z400A	Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A	Yes	Multiple independent operative procedures at one time are each claimed in full (SP4 §13).
Z560A	Z399A, Z400A	No	Duodenoscopy isn't payable within 3 months of Z399A or Z400A (S15).
S236A,S237A	Z399A, Z400A, Z496A, Z497A, Z527A	Sometimes	Upper or lower endoscopy with EUS pays \$0 unless needed because of limited visualization with the echo-endoscope (S6).
S236A	S237A	No	S236A pays \$0 with S237A (S6).
E800A	E801A	No	E800A pays \$0 with E801A (S6).
E674A,E675A	Z399A, Z400A	No	E674A/E675A go with Z527A, Z528A or Z547A; with Z399A use E703A/E799A (S7, S11).

Code	With	Together ?	Why
E703A,E799A	Z527A, Z528A, Z547A	No	E703A/E799A are add-ons to oesophagoscopy-gastroscopy Z399A/Z400A; with Z527A use E674A/E675A (S7, S11).
Z588A	Z399A, Z400A, Z496A, Z584A, E797A	No	Double balloon enteroscopy is all-inclusive; only E250A time can be added (S15).
E098A	A415A, A416A, A545A, C413A, C414A, C411A	No	E098A adds only to office/clinic A413A, A414A, A411A or A418A, not consults or in-patients (A104).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
G254A	C412A, C417A, C419A, C122A, C123A, C124A	No	G254A is not payable with a subsequent visit or assessment (J45).
C142A	C122A	No	Only one of C122A or C142A per admission (GP46).
C143A	C123A	No	Only one of C123A or C143A per admission (GP46).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as a discharge visit C124A or C126A (GP46).
Z514A	Z512A	No	Z514A is the stoma scope with biopsy; bill one or the other (S15).
K731A,K739A	A415A, A416A, A545A, A413A, A414A, A411A, A418A, C415A, C413A, C412A	Sometimes	Your phone advice (K731A) or e-consult reply (K739A) isn't paid if you see the patient yourself (consult, assessment, visit or K time code) the same day or the next (A43, A49).
A413A,A414A,A411A	Z399A, Z400A, Z515A, Z527A, Z528A, Z547A, Z558A, Z561A, Z760A	Sometimes	Only when this assessment is where you decided to scope (major pre-operative visit, GP4); then nothing else before the scope. If you decided at an earlier visit in the last 12 months, only a partial assessment A418A is payable before it (SP4 §13).
A418A	Z399A, Z400A, Z515A, Z527A, Z528A, Z547A, Z558A, Z561A, Z760A	Yes	When you decided on the scope at an earlier visit in the last 12 months, a partial assessment is the one assessment payable before it the same day (SP4 §13).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (A104–A106, A31–A33, A42–A49, A58–A60, GP16–GP24, GP40–GP47, GP50, GP64–GP72, GP104, SP2, SP4, S6–S7, S11, S15–S19, S25–S30, J7, J44–J45, J54). Scope fees shown are the surgeon (A) fee; anaesthesia is billed separately by the anaesthetist (E032C for colonoscopy). Diagnostic tests show the professional (interpretation) fee only. The total leaves out the under-16 age premiums OHIP adds to consults and procedures (GP64). For services not listed under Gastroenterology, use the Internal Medicine listings (A104).

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