

# General Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 03 · Office procedure · Endoscopy · Called to ED or ward · Updated October 2026

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

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

## Office consultation

|              |                                                                                                                                                                                                                 |                 |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>A035A</b> | <b>Consultation</b><br>Written referral from a physician or NP; written report back. Limit: 1 per patient per 2 years for the same diagnosis (GP17).                                                            | <b>\$114.75</b> |
| <b>A935A</b> | <b>Long consultation, 50+ minutes</b><br>Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart review. Chart start and stop times (GP19–GP20). | <b>\$194.65</b> |
| <b>A036A</b> | <b>Repeat consultation</b><br>Same problem, new written referral, after another physician cared for the patient in between (GP19).                                                                              | <b>\$76.45</b>  |

- 50+ minutes face to face? A935A pays \$194.65, \$79.90 more than A035A. Procedure time and charting don't count (GP19–GP20).
- This is usually your decision-to-operate visit: it's paid on top of the surgery whenever the surgery happens (SP2).
- Did a Z-code procedure (abscess, biopsy, excision) today that you decided on at this consult? Bill both. Next time, only A034A can go before a planned Z-code procedure (SP4 §13).
- A second consult for the same diagnosis within 2 years is paid as a specific assessment, unless it's a repeat consult or an in-patient/ED consult 12–24 months later (GP17).
- A consultation done only to prepare a patient for colonoscopy under local or IV sedation is paid only when the chart shows it was medically necessary (GP18).

## Office follow-up

|              |                                                                                                                                                                                                                                             |                |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>A034A</b> | <b>Follow-up or post-op visit</b><br>History of the problem, the exam needed, advice. Partial assessment.                                                                                                                                   | <b>\$34.10</b> |
| <b>A033A</b> | <b>Full work-up of one problem</b><br>Full history of the complaint and detailed exam of the affected area. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23). | <b>\$56.40</b> |

- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Phoned or e-consulted another physician about this patient? K730A (\$37.05) or K738A (\$16.45) is paid on top of today's visit (A42, A48). Sending them home with home care: K070A (\$34.75) (A58).
- Your office has no specific re-assessment code: routine follow-ups are A034A. A033A is limited to 1 a year per patient (2 for a clearly different diagnosis) (GP23).
- Planned Z-code procedure today, decided at an earlier visit? A034A is the only visit payable before it (SP4 §13), unless you also treated a separate, significant problem in another body system: then bill the procedure and the assessment (SP4 §12).
- E078A (chronic disease premium) isn't payable to general surgery (03): 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.

## Office procedure

- Tray fee E542A (\$12.65) goes only on listed codes done outside hospital; it's built into the choices below (M1, S27).
- A 5–10 cm lipoma is Z096A (\$87.65), not Z125A (\$35.05) (M4). Use specific listings over generic skin codes (SP4 §14).
- Two or three abscesses at once: Z173A or Z174A instead of Z101A (M1).
- Haemorrhoid treatments include anoscopy: don't add Z543A (S27). Barron ligation and injections: max 6 a year each (S28).
- Rigid sigmoidoscopy in the office adds E746A (\$5.85); not with Z555A or Z580A (S25).

## Endoscopy

|              |                                                                                                                                                                             |                |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>Z496A</b> | <b>Colonoscopy for symptoms</b><br>Bleeding, anaemia, change in bowel habit, pain.                                                                                          | <b>\$51.95</b> |
| <b>Z497A</b> | <b>Colonoscopy after a positive FIT, sigmoidoscopy, enema or CT S16.</b>                                                                                                    | <b>\$51.95</b> |
| <b>Z555A</b> | <b>Screening colonoscopy, average risk, 50+</b><br>No symptoms or risk factors. Limit: Uninsured within 10 years of the last Z555A (S17).                                   | <b>\$51.95</b> |
| <b>Z498A</b> | <b>Surveillance after polyps or cancer</b><br>At guideline intervals (S17). Family history: Z499A; IBD or hereditary: Z494A; incomplete polypectomy within 6 months: Z491A. | <b>\$51.95</b> |
| <b>Z580A</b> | <b>Flexible sigmoidoscopy (60 cm)</b><br>Not with a colonoscopy code the same day (S15).                                                                                    | <b>\$57.70</b> |
| <b>Z399A</b> | <b>Upper endoscopy (oesophagus, stomach, duodenum)</b><br>Elective. Active bleeding: Z400A (\$125.10).                                                                      | <b>\$92.50</b> |
| <b>Z527A</b> | <b>Gastroscopy</b><br>May include biopsies, photos and polyps up to 1 cm. Repeat within 3 months: Z528A (\$67.85); with foreign body removal: Z547A (\$99.75) (S11).        | <b>\$82.90</b> |

- The colonoscopy base code only covers sigmoid to descending colon: add E740A + E741A + E747A for reaching the cecum, \$114.05 more (S18).
- First polyp is one code by the largest size (\$150.15); up to 2 more add \$77.50 each. Polyps under 3 mm aren't paid; fulguration is included (S19).
- Colonoscopy in your private office adds E749A (\$22.35); not in a hospital or ICHSC (S18–S19).
- Only one colonoscopy base code per day, and Z580A isn't paid with any of them (S15, S17).
- Upper scope through the oesophagus is Z399A (\$92.50); gastroscopy alone Z527A pays \$82.90 (S7, S11).

## Called to ED or ward

|              |                                                                                                     |                 |
|--------------|-----------------------------------------------------------------------------------------------------|-----------------|
| <b>A035A</b> | <b>Consultation</b><br>Requested by the ED or ward physician. Written report.                       | <b>\$114.75</b> |
| <b>A935A</b> | <b>Long consultation, 50+ minutes</b><br>50+ minutes face to face, excluding procedures (GP19).     | <b>\$194.65</b> |
| <b>A036A</b> | <b>Repeat consultation</b><br>Same problem, new request, after another physician's care in between. | <b>\$76.45</b>  |
| <b>A033A</b> | <b>Full work-up, your own patient</b><br>Specific assessment.                                       | <b>\$56.40</b>  |
| <b>A034A</b> | <b>Brief assessment</b><br>Partial assessment.                                                      | <b>\$34.10</b>  |

- Use A-prefix codes plus the premiums when called in non-electively, not C-codes (GP43, GP65).
- The premiums shown are the ED table (I). For an in-patient on a ward (table III, C9xx) or an out-patient clinic (table II, U9xx) the amounts are the same; bill that table's codes (GP71–GP72).
- Weekday daytime emergency surgery: consult + special visit premium + procedure. Evenings, nights, weekends: add E409A or E410A to the procedure (SP2 §2).
- Admitting the patient as MRP? E082A adds 30% to this consult, once per admission (GP42).
- Took the patient to the OR? Pick Emergency surgery for the operation (SP2 §2).

## Emergency surgery

|              |                                                                                                                                                                             |                 |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>S207A</b> | <b>Appendectomy</b><br>Perforated or not. Abscess drainage codes not paid with it (S23).                                                                                    | <b>\$524.60</b> |
| <b>S287A</b> | <b>Cholecystectomy</b><br>Open or laparoscopic (S31).                                                                                                                       | <b>\$544.30</b> |
| <b>S329A</b> | <b>Incarcerated or strangulated hernia, no bowel resection</b><br>S37.                                                                                                      | <b>\$425.00</b> |
| <b>S330A</b> | <b>Incarcerated or strangulated hernia with bowel resection</b><br>S37.                                                                                                     | <b>\$660.50</b> |
| <b>S312A</b> | <b>Exploratory laparotomy</b><br>With or without biopsy. Not with other intra-abdominal procedures (S34).                                                                   | <b>\$485.25</b> |
| <b>S321A</b> | <b>Laparotomy for acute trauma</b><br>Add the repairs you did below (S34).                                                                                                  | <b>\$671.65</b> |
| <b>Z105A</b> | <b>Perianal abscess drained under general anaesthetic</b><br>Sole procedure in the OR: add E515A (M1). Skin abscess under GA: Z102A (\$48.60), two or more Z172A (\$72.95). | <b>\$72.30</b>  |

- Bill the ED consult with its travel and first-person premiums from the Called to ED tile; it's payable with the operation (SP2 §2).
- Started 17:00–24:00 weekdays or any time on a weekend or holiday: E409A +50%; 00:00–07:00: E410A +75% (GP104). An elective case pushed into those hours by an emergency qualifies too (GP103–GP104).
- Laparoscopy converted to laparotomy: add E860A (\$131.45) (SP5 §23). 60+ minutes of adhesiolysis: E673A (\$124.10) (SP7).
- An incidental normal appendix removed during another operation isn't billed (SP2 §3).
- E400/E401 are the assistant's and anaesthetist's after-hours premiums, not yours (GP87, GP95).

## Booked surgery (OR)

|              |                                                                                                                                             |                   |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| <b>S323A</b> | <b>Inguinal or femoral hernia, adult</b><br>Recurrent: add E725A.                                                                           | <b>\$357.80</b>   |
| <b>S332A</b> | <b>Umbilical hernia, adult</b>                                                                                                              | <b>\$324.20</b>   |
| <b>S344A</b> | <b>Ventral or incisional hernia, 5 cm+, mesh</b><br>Under 5 cm or primary closure: S340A (\$370.95) (S37).                                  | <b>\$569.35</b>   |
| <b>S287A</b> | <b>Cholecystectomy</b>                                                                                                                      | <b>\$544.30</b>   |
| <b>R111A</b> | <b>Partial mastectomy / lumpectomy</b><br>Diagnostic excision of a breast lump: R107A (\$169.95) (M25).                                     | <b>\$306.75</b>   |
| <b>S247A</b> | <b>Haemorrhoidectomy</b><br>Insured only after failed non-surgical therapy, grade III–IV, or substantial skin tags (S28).                   | <b>\$260.15</b>   |
| <b>S167A</b> | <b>Colectomy, any portion of large bowel</b><br>Resection with anastomosis, e.g. sigmoid. Low anterior resection: S171A (\$1,290.55) (S20). | <b>\$1,004.40</b> |
| <b>S166A</b> | <b>Right hemicolectomy</b><br>S20.                                                                                                          | <b>\$1,029.45</b> |

- The decision-to-operate visit is always billed separately, whenever it was. The day-surgery or admission assessment isn't, unless it was that visit (SP2).
- Second procedure under the same anaesthetic, including the other side: 85% of its fee (SP2 §3).
- Recurrent hernia adds E725A (\$130.00); a repeat recurrent inguinal hernia (more than 2 repairs) adds E726A (\$257.35). An umbilical hernia fixed during other abdominal surgery adds E764A (\$27.55) if it was charted before surgery (S37).
- Laparoscopic colectomy or mesh ventral hernia: E793A adds 25% (S20, S38). BMI over 40 under general anaesthetic: E676A +25%, once per patient, BMI in the chart (SP6–SP7).
- Breast: wire or seed localization adds E525A; axillary dissection E546A. E505A node sampling isn't paid with Z427A sentinel node (M25).

## In-patient consult

|              |                                                                                                                                        |                 |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>C035A</b> | <b>Consultation</b><br>Requested by the attending physician, routine (not a called-in visit).                                          | <b>\$114.75</b> |
| <b>C935A</b> | <b>Long consultation, 50+ minutes</b><br>50+ minutes face to face (GP19).                                                              | <b>\$194.65</b> |
| <b>C036A</b> | <b>Repeat consultation</b>                                                                                                             | <b>\$76.45</b>  |
| <b>C033A</b> | <b>Full work-up</b><br>Specific assessment.                                                                                            | <b>\$56.40</b>  |
| <b>C034A</b> | <b>Re-assessment</b><br>Specific re-assessment. 2 per 12 months except admissions (GP23).                                              | <b>\$36.75</b>  |
| <b>C038A</b> | <b>Concurrent care</b><br>You keep following the patient while another physician is the MRP. Limit: 4 in week 1, then 2 a week (GP48). | <b>\$34.10</b>  |

- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2, GP40).
- Elective surgical admission and you did a pre-op assessment in the last 30 days: no admission assessment (GP41).
- Called in urgently instead? Use the ED or ward tile for A-codes and premiums.
- Second surgeon brought in on consultation who then operates or assists may also claim the consult, justified on an IC basis (SP3 §8).
- Concurrent care is 4 claims in the first week and 2 a week after; it never takes E083A (GP47–GP48).

## Hospital rounds

|              |                                                                                                                                                                                                                                  |                |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>C122A</b> | <b>Day after admission, you're the MRP</b><br>Once per admission (GP44).                                                                                                                                                         | <b>\$71.80</b> |
| <b>C123A</b> | <b>Second day after admission, you're the MRP</b><br>Once per admission (GP44).                                                                                                                                                  | <b>\$71.80</b> |
| <b>C142A</b> | <b>First visit after transfer out of ICU, you're the MRP</b><br>Patient was getting critical, ventilatory or comprehensive care, not just monitoring, and you didn't give that care. One of C122A or C142A per admission (GP46). | <b>\$71.80</b> |
| <b>C143A</b> | <b>Second visit after transfer out of ICU, you're the MRP</b><br>Same conditions. One of C123A or C143A per admission (GP46).                                                                                                    | <b>\$71.80</b> |
| <b>C032A</b> | <b>Routine daily visit</b><br>1 a day in weeks 1–5; then C037A (3 a week) and C039A (6 a month) (GP43).                                                                                                                          | <b>\$34.10</b> |
| <b>C124A</b> | <b>Discharge day, you're the MRP</b><br>Stay over 48 hours; discharge summary within 48 hours (GP45).                                                                                                                            | <b>\$71.80</b> |
| <b>C126A</b> | <b>Discharge day, complex patient</b><br>Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes (A13).                                                                                                                          | <b>\$95.10</b> |
| <b>C121A</b> | <b>Extra visit for an acute intercurrent illness</b><br>After week 5, when the weekly or monthly limit is used up; the limits don't apply to it (GP43).                                                                          | <b>\$40.05</b> |

- As MRP after surgery, C122A and C123A pay \$71.80 instead of \$34.10 for the first two days (GP44).
- E083A adds 30% to your MRP visits; the Schedule names C032A, C037A and C039A as examples (GP47). The E084A weekend premium is not open to General Surgery (GP47).
- Patient came to your ward from the ICU? C142A and C143A pay \$71.80 for your first two visits, in place of C122A/C123A; not if you gave the critical care (GP46).
- Palliative patient you're MRP for: C982A (\$40.05) per visit, and E083A applies to it (GP47, GP50).
- Surgery cancelled before induction counts as a subsequent visit; after induction with you scrubbed, bill E006A (SP7 §27).

## Long-term care

|              |                                                                                                                                                                                             |                 |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>W035A</b> | <b>Consultation</b><br>Chronic care or convalescent hospital, nursing home, home for the aged. Written request; report back.                                                                | <b>\$114.75</b> |
| <b>W036A</b> | <b>Repeat consultation</b><br>Same problem, new request, after another physician's care in between.                                                                                         | <b>\$76.45</b>  |
| <b>W032A</b> | <b>Visit, chronic care or convalescent hospital</b><br>First 4 subsequent visits per patient per month (A108).                                                                              | <b>\$40.05</b>  |
| <b>W031A</b> | <b>More visits, chronic care or convalescent hospital</b><br>After the first 4. Max 6 per patient per month (A108).                                                                         | <b>\$40.05</b>  |
| <b>W033A</b> | <b>Visit, nursing home or home for the aged</b><br>First 2 subsequent visits per patient per month (A108).                                                                                  | <b>\$40.05</b>  |
| <b>W038A</b> | <b>More visits, nursing home or home for the aged</b><br>After the first 2. Max 3 per patient per month (A108).                                                                             | <b>\$40.05</b>  |
| <b>W121A</b> | <b>Extra visit for an acute intercurrent illness</b><br>Not a special visit; paid whether or not the monthly limit is reached (GP49).                                                       | <b>\$40.05</b>  |
| <b>W124A</b> | <b>Discharge day</b><br>Resident 30+ consecutive days, discharge summary with follow-up, going to another facility or home where someone else takes over care. Not for respite stays (A20). | <b>\$71.80</b>  |

- Called to see another physician's patient urgently, or any special visit? Bill the A-prefix consult or assessment (A035A, A033A, A034A) plus the long-term care special visit premiums (W960A–W964A), not W visit codes (GP49, GP73).
- Monthly limits: chronic care hospital 4 + 6 more visits, nursing home 2 + 3 more. Acute intercurrent illness visits are W121A, whether or not the limit is reached (A108, GP49).
- Palliative visits: W982A in a chronic care hospital, W972A in a nursing home (\$40.05). Designated palliative care bed: C982A instead (GP50).

## Also bill, if it's true

|                              |                                                                                                                                                                                          |          |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| <b>A034A</b>                 | Also a brief assessment before the procedure<br>Partial assessment. The only visit allowed before a planned Z-code procedure when you decided on it at an earlier visit (SP4 §13).       | \$34.10  |
| <b>E740A + E741A + E747A</b> | Reached the cecum<br>Splenic flexure E740A, hepatic flexure E741A, cecum E747A (S18).                                                                                                    | \$114.05 |
| <b>E740A</b>                 | Reached the splenic flexure only<br>S18.                                                                                                                                                 | \$51.75  |
| <b>E705A</b>                 | Intubated the terminal ileum<br>S18.                                                                                                                                                     | \$30.30  |
| <b>Z517A</b>                 | Removed a polyp 3 mm or larger<br>One code by the largest polyp: Z571A 3–5 mm, Z518A 6–9, Z517A 10–19, Z516A 20–29; same fee. 1 per day (S19).                                           | \$150.15 |
| <b>E519A</b>                 | Each additional polyp<br>E720A, E520A, E519A or E518A by size. Max 2 a day (S19).                                                                                                        | \$77.50  |
| <b>E717A</b>                 | Biopsies or coagulated angiodysplasia<br>One or more. Not with E785A (S18).                                                                                                              | \$27.05  |
| <b>E749A</b>                 | Done in your private office<br>Not in a hospital or ICHSC (S18–S19).                                                                                                                     | \$22.35  |
| <b>Z399A</b>                 | Also did an upper endoscopy<br>Same session (S7).                                                                                                                                        | \$92.50  |
| <b>E797A</b>                 | Treated bleeding (clip, injection, cautery, banding)<br>Uncomplicated bleeding; to Z399A, Z496A or Z497A (S7, S18).                                                                      | \$46.30  |
| <b>E798A</b>                 | Treated complicated bleeding, unstable patient<br>Haemodynamically unstable with active bleeding during the scope, any technique (S7).                                                   | \$69.70  |
| <b>E696A</b>                 | Dilated the oesophagus<br>Pneumatic or balloon dilation: E698A (\$69.70) (S7).                                                                                                           | \$30.65  |
| <b>E690A</b>                 | Removed a foreign body or stent<br>Includes removing a stent (S7).                                                                                                                       | \$43.85  |
| <b>E702A</b>                 | 3+ biopsies of one lesion<br>S7.                                                                                                                                                         | \$15.10  |
| <b>E703A</b>                 | Snare polypectomy, polyp over 1 cm<br>First polyp; each further one E799A (S7).                                                                                                          | \$50.50  |
| <b>E799A</b>                 | Each more snared polyp over 1 cm<br>After E703A. Max 2 (S7).                                                                                                                             | \$25.25  |
| <b>E674A</b>                 | Snare polypectomy, first polyp over 1 cm<br>With gastroscopy (S11).                                                                                                                      | \$142.40 |
| <b>E675A</b>                 | Each more snared polyp over 1 cm<br>After E674A. Max 2 (S11).                                                                                                                            | \$73.50  |
| <b>E082A</b>                 | You admitted the patient and are the MRP<br>This consult is your admission assessment. Once per admission; not for day surgery; not if the hospital pays you for in-patient work (GP42). | +30%     |
| <b>E409A</b>                 | Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening<br>Non-elective. +50% of the procedures ticked below, not the consult (GP103–GP104).                            | +50%     |
| <b>E410A</b>                 | Procedure started at night, 00:00–07:00<br>Non-elective. +75% of the procedures ticked below, not the consult (GP103–GP104).                                                             | +75%     |
| <b>E409A</b>                 | Started 17:00–24:00 weekday, or weekend/holiday day or evening<br>Non-elective (or delayed by an emergency). +50% of this operation and any procedure ticked below (GP104).              | +50%     |
| <b>E410A</b>                 | Started at night, 00:00–07:00<br>Non-elective (or delayed by an emergency). +75% of this operation and any procedure ticked below (GP104).                                               | +75%     |

|              |                                                                                                                                                                                                                                                                       |          |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| <b>E083A</b> | <b>You're the MRP</b><br>+30% on MRP subsequent visits. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).                                                                                                                             | +30%     |
| <b>A035A</b> | <b>Consult that led to this surgery</b><br>Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).                                                                                                                                 | \$114.75 |
| <b>A033A</b> | <b>Assessed your own patient before the surgery</b><br>Specific assessment (SP2 §2).                                                                                                                                                                                  | \$56.40  |
| <b>A035A</b> | <b>Decided to operate at a consult today</b><br>The major pre-op visit is paid on top of the surgery (SP2).                                                                                                                                                           | \$114.75 |
| <b>E515A</b> | <b>Abscess drainage was the only procedure, under GA in the OR</b><br>+110%. Not in the ED (M1).                                                                                                                                                                      | +110%    |
| <b>E794A</b> | <b>Intra-operative cholangiogram</b><br>S31.                                                                                                                                                                                                                          | \$40.80  |
| <b>E860A</b> | <b>Started laparoscopically, converted to open</b><br>SP5 §23.                                                                                                                                                                                                        | \$131.45 |
| <b>E673A</b> | <b>60+ minutes of adhesiolysis</b><br>Less than 60 minutes is included (SP7).                                                                                                                                                                                         | \$124.10 |
| <b>E676A</b> | <b>BMI over 40, general anaesthetic</b><br>+25%, once per patient. BMI charted; open or laparoscopic abdominal surgery. Only with the codes listed on SP6 (S330A isn't one) (SP6–SP7).                                                                                | +25%     |
| <b>S323A</b> | <b>Other side too (bilateral)</b><br>Second side at 85% (SP2 §3).                                                                                                                                                                                                     | +85%     |
| <b>E725A</b> | <b>Recurrent hernia</b><br>S37.                                                                                                                                                                                                                                       | \$130.00 |
| <b>E726A</b> | <b>Repeat recurrent inguinal hernia, more than 2 repairs</b><br>To S322A, S323A, S326A, S329A or S330A (S37).                                                                                                                                                         | \$257.35 |
| <b>E829A</b> | <b>Component separation, defect 5–10 cm</b><br>S37.                                                                                                                                                                                                                   | \$341.60 |
| <b>E827A</b> | <b>Component separation, defect over 10 cm</b><br>S37.                                                                                                                                                                                                                | \$683.20 |
| <b>E793A</b> | <b>Done laparoscopically or laparoscopic-assisted</b><br>+25% to bowel resections S165A–S172A and to S344A (S20, S38).                                                                                                                                                | +25%     |
| <b>E796A</b> | <b>Mobilized the splenic flexure</b><br>To S167A (S20).                                                                                                                                                                                                               | \$117.15 |
| <b>E733A</b> | <b>Repaired the intestine, single</b><br>Multiple and/or with resection: E734A instead (S34).                                                                                                                                                                         | \$162.90 |
| <b>E734A</b> | <b>Repaired the intestine, multiple and/or resected</b><br>S34.                                                                                                                                                                                                       | \$241.55 |
| <b>E735A</b> | <b>Splenectomy, partial or complete</b><br>S34.                                                                                                                                                                                                                       | \$325.80 |
| <b>E723A</b> | <b>Repaired a lacerated spleen</b><br>S34.                                                                                                                                                                                                                            | \$325.85 |
| <b>E736A</b> | <b>Repaired a lacerated liver</b><br>S34.                                                                                                                                                                                                                             | \$214.95 |
| <b>E420A</b> | <b>Trauma patient with ISS over 15 (over 12 under age 16)</b><br>+50% on this consult, assessment or operation and any procedure ticked, on the day of the trauma or within 24 h. ISS in the chart; same claim. Not on special visit or after-hours premiums (GP109). | +50%     |
| <b>K036A</b> | <b>Northern Health Travel Grant form</b><br>Your part of the form for a patient travelling from Northern Ontario. Paid to the referring physician and the specialist (A60).                                                                                           | \$10.25  |
| <b>K070A</b> | <b>Home care referral form</b><br>You're the most responsible physician sending the patient to Ontario Health atHome (wound care, drains, IV). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).                         | \$34.75  |

|              |                                                                                                                                                                                                                                                                                                                                   |                 |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>K730A</b> | <b>Phoned another physician for advice</b><br>10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test, or mainly to discuss results. Start and stop times charted. 1 a day. Paid on top of the visit (A42–A43).                                                                    | <b>\$37.05</b>  |
| <b>K738A</b> | <b>Sent an e-consult to another physician</b><br>Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months. Paid on top of the visit (A48–A49).                                                                                                                                                            | <b>\$16.45</b>  |
| <b>K708A</b> | <b>Discussed at a cancer conference (MCC) today</b><br>Pre-scheduled MCC to Ontario Health standards, you took part (chair: K709A, \$47.75). Payable the same day as a visit; nothing done during the conference is paid (A29).                                                                                                   | <b>\$37.05</b>  |
| <b>K121A</b> | <b>In-patient case conference, per unit</b><br>Pre-scheduled, with the MRP and 2+ others (physicians, social workers, regulated health professionals), 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months. Anything done during the conference isn't paid; your visit outside it is (A31–A33). | <b>\$37.05</b>  |
| <b>E764A</b> | <b>Also repaired an umbilical hernia</b><br>Pre-existing hernia documented before surgery (S37).                                                                                                                                                                                                                                  | <b>\$27.55</b>  |
| <b>E525A</b> | <b>After wire or seed localization</b><br>M25.                                                                                                                                                                                                                                                                                    | <b>\$48.05</b>  |
| <b>E546A</b> | <b>Axillary node dissection</b><br>Up to the axillary vein (M25).                                                                                                                                                                                                                                                                 | <b>\$388.75</b> |
| <b>Z427A</b> | <b>Sentinel node biopsy</b><br>Per draining basin. With E546A only if frozen section shows micrometastases (M25, R2).                                                                                                                                                                                                             | <b>\$330.45</b> |
| <b>E505A</b> | <b>Limited axillary node sampling</b><br>Not with Z427A (M25).                                                                                                                                                                                                                                                                    | <b>\$178.05</b> |

## Did a procedure?

|                      |                                                                                                                                                                                                                                                                       |          |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| <b>Z101A + E542A</b> | Abscess drained, one                                                                                                                                                                                                                                                  | \$40.85  |
| <b>Z173A + E542A</b> | Abscesses drained, two                                                                                                                                                                                                                                                | \$45.90  |
| <b>Z174A + E542A</b> | Abscesses drained, three or more                                                                                                                                                                                                                                      | \$57.35  |
| <b>Z104A + E542A</b> | Perianal abscess drained, local                                                                                                                                                                                                                                       | \$45.90  |
| <b>Z106A + E542A</b> | Pilonidal or ischiorectal abscess drained, local                                                                                                                                                                                                                      | \$61.25  |
| <b>Z125A + E542A</b> | Cyst or lipoma removed, body<br>One lesion. Two: Z126A (\$49.30); three or more: Z127A (\$65.75), each + E542A (M4).                                                                                                                                                  | \$47.70  |
| <b>Z122A + E542A</b> | Cyst or lipoma removed, face or neck<br>One lesion. Two: Z123A (\$74.30); three or more: Z124A (\$85.45), each + E542A (M4).                                                                                                                                          | \$54.85  |
| <b>Z096A + E542A</b> | Lipoma 5–10 cm<br>M4.                                                                                                                                                                                                                                                 | \$100.30 |
| <b>Z116A + E542A</b> | Skin biopsy with stitches                                                                                                                                                                                                                                             | \$45.10  |
| <b>Z113A</b>         | Skin biopsy, no stitches                                                                                                                                                                                                                                              | \$32.45  |
| <b>Z114A + E542A</b> | Foreign body removed, local<br>Under general anaesthetic: Z115A (\$97.30) (M1).                                                                                                                                                                                       | \$40.30  |
| <b>Z176A + E542A</b> | Laceration up to 5 cm<br>On the face, layered or tying bleeders: Z154A (\$39.35). Glue only: 50% (M15).                                                                                                                                                               | \$34.55  |
| <b>Z175A + E542A</b> | Laceration 5.1–10 cm<br>Face or layered: Z177A (\$78.15). 10.1–15 cm: Z179A (\$55.20), face or layered Z190A (\$111.20); over 15 cm Z191A (\$84.70) (M15).                                                                                                            | \$52.00  |
| <b>Z128A + E542A</b> | Ingrown nail removed<br>One nail. Several: Z129A (\$39.20). Radical, with nail bed destruction: Z130A (\$68.75) (M23).                                                                                                                                                | \$48.95  |
| <b>Z545A + E542A</b> | Thrombosed haemorrhoid                                                                                                                                                                                                                                                | \$37.90  |
| <b>Z546A</b>         | Haemorrhoid banding<br>Max 6 a year (S28).                                                                                                                                                                                                                            | \$39.40  |
| <b>Z575A</b>         | Haemorrhoid injection<br>Max 6 a year (S28).                                                                                                                                                                                                                          | \$27.05  |
| <b>Z543A</b>         | Anoscopy<br>Not with haemorrhoid or anal wart treatment (S27).                                                                                                                                                                                                        | \$8.70   |
| <b>Z535A + E746A</b> | Rigid sigmoidoscopy, office                                                                                                                                                                                                                                           | \$42.65  |
| <b>Z536A + E746A</b> | Rigid sigmoidoscopy with biopsy, office                                                                                                                                                                                                                               | \$50.40  |
| <b>Z548A</b>         | Anal fissure cauterized                                                                                                                                                                                                                                               | \$34.90  |
| <b>Z576A</b>         | Anal fissure injection (e.g. Botox)                                                                                                                                                                                                                                   | \$35.90  |
| <b>Z757A + E542A</b> | Benign anal lesion excised                                                                                                                                                                                                                                            | \$59.80  |
| <b>Z141A + E542A</b> | Breast needle biopsy                                                                                                                                                                                                                                                  | \$49.85  |
| <b>Z139A</b>         | Breast cyst aspiration<br>One or more.                                                                                                                                                                                                                                | \$37.20  |
| <b>Z143A</b>         | Breast core biopsy, 14 gauge or larger                                                                                                                                                                                                                                | \$144.85 |
| <b>Z140A</b>         | Breast abscess drained, local                                                                                                                                                                                                                                         | \$33.00  |
| <b>Z118A</b>         | Aspiration of a superficial lump for cytology                                                                                                                                                                                                                         | \$30.95  |
| <b>Z771A</b>         | Thyroid fine needle aspiration                                                                                                                                                                                                                                        | \$38.00  |
| <b>Z756A</b>         | Fecal disimpaction, no anaesthetic<br>Severe refractory impaction, done personally (S27).                                                                                                                                                                             | \$46.00  |
| <b>Z080A + E542A</b> | Wound or ulcer debridement into fat, one<br>10+ min, done by you, time charted. Two Z081A, three Z082A, 4+ Z083A; into tendon or bone Z084A. Not after your own surgery unless a complication needs more than usual post-op care; not with a laceration repair (M10). | \$34.55  |

## Can I bill these together?

| Code                                       | With                                                                                                                                                                                                                    | Together ? | Why                                                                                                                                                                                                                  |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>E078A</b>                               | A033A, A034A                                                                                                                                                                                                            | No         | E078A is only paid to the specialties listed in GP25; General Surgery (03) isn't one of them (GP25).                                                                                                                 |
| <b>A035A,A036A,A033A,A935A</b>             | Z101A, Z104A, Z106A, Z125A, Z122A, Z096A, Z116A, Z545A, Z546A, Z141A, Z143A, Z757A, Z535A                                                                                                                               | Sometimes  | Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A034A) is payable before it that day (SP4 §13).                                         |
| <b>A034A</b>                               | Z101A, Z173A, Z174A, Z104A, Z106A, Z125A, Z122A, Z096A, Z116A, Z113A, Z114A, Z176A, Z175A, Z128A, Z545A, Z546A, Z575A, Z543A, Z535A, Z536A, Z548A, Z576A, Z757A, Z141A, Z139A, Z143A, Z140A, Z118A, Z771A, Z756A, Z080A | Yes        | A partial assessment is allowed before a planned Z-code procedure, and is paid with it when it's the visit where you decided on it (SP4 §13).                                                                        |
| <b>A035A,A935A,A036A,C035A,C935A,C036A</b> | S207A, S287A, S329A, S330A, S312A, S321A, S323A, S332A, S344A, S340A, S247A, S167A, S166A, S171A, R111A, R107A                                                                                                          | Yes        | The consult where you decide to operate is the major pre-operative visit: never included in the surgical fee, whenever the surgery happens, even the same day (SP2, GP4).                                            |
| <b>A033A,A034A,C033A,C034A</b>             | S207A, S287A, S329A, S330A, S312A, S321A, S323A, S332A, S344A, S340A, S247A, S167A, S166A, S171A, R111A, R107A                                                                                                          | Sometimes  | Only when this is the visit where you decided to operate. A hospital or day-surgery admission assessment that isn't that visit isn't paid (SP2).                                                                     |
| <b>Z543A</b>                               | Z546A, Z575A, Z565A, S247A, Z549A                                                                                                                                                                                       | No         | Haemorrhoid excision, ligation and injection and anal wart treatments include anoscopy (S27).                                                                                                                        |
| <b>Z543A</b>                               | Z545A                                                                                                                                                                                                                   | Sometimes  | S27 bundles anoscopy only into excision, ligation or injection of haemorrhoids and wart treatment; incising a thrombosed haemorrhoid (Z545A) isn't on that list, so an anoscopy done for its own reason is billable. |
| <b>Z535A</b>                               | Z555A, Z580A                                                                                                                                                                                                            | No         | Rigid sigmoidoscopy isn't billed with Z555A or Z580A (S25).                                                                                                                                                          |
| <b>Z580A</b>                               | Z491A, Z492A, Z493A, Z494A, Z495A, Z496A, Z497A, Z498A, Z499A, Z555A                                                                                                                                                    | No         | Flexible sigmoidoscopy isn't paid with a colonoscopy the same day (S15).                                                                                                                                             |
| <b>Z496A</b>                               | Z491A, Z492A, Z493A, Z494A, Z495A, Z497A, Z498A, Z499A, Z555A                                                                                                                                                           | No         | Only one colonoscopy base code per patient per day (S17).                                                                                                                                                            |
| <b>Z571A</b>                               | Z518A, Z517A, Z516A                                                                                                                                                                                                     | No         | Only one first-polyp code per day; use the largest polyp's size (S19).                                                                                                                                               |
| <b>E740A,E741A,E747A,E705A</b>             | Z496A, Z497A, Z555A, Z498A, Z499A, Z494A                                                                                                                                                                                | Yes        | Extent add-ons are paid on top of the colonoscopy base code (S18).                                                                                                                                                   |
| <b>E717A</b>                               | E785A                                                                                                                                                                                                                   | No         | E717A isn't paid with E785A (S18).                                                                                                                                                                                   |
| <b>Z560A</b>                               | Z399A                                                                                                                                                                                                                   | No         | Duodenoscopy isn't claimed within 3 months of Z399A or Z400A (S15).                                                                                                                                                  |
| <b>S207A</b>                               | S204A, S313A, S314A, Z594A, E686A                                                                                                                                                                                       | No         | Abscess drainage codes aren't paid with an appendectomy (S23).                                                                                                                                                       |
| <b>E505A</b>                               | Z427A                                                                                                                                                                                                                   | No         | Limited axillary sampling isn't paid with a sentinel node biopsy (M25).                                                                                                                                              |

| Code                           | With                                                                        | Together ? | Why                                                                                                                                                                                              |
|--------------------------------|-----------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Z427A</b>                   | E546A                                                                       | Sometimes  | Only when the frozen section shows micrometastases (M25).                                                                                                                                        |
| <b>E409A</b>                   | E410A                                                                       | No         | One after-hours premium per case, by the time the procedure started (GP104).                                                                                                                     |
| <b>E515A</b>                   | Z105A, Z102A, Z107A                                                         | Yes        | +110% when the abscess drainage is the sole procedure under GA in an OR, not in the ED (M1).                                                                                                     |
| <b>S318A</b>                   | S344A, S287A                                                                | Sometimes  | Panniculectomy with another abdominal procedure is paid only when its own Appendix D criteria and Ministry prior authorization are met separately (S36).                                         |
| <b>S318A</b>                   | S332A                                                                       | No         | Umbilical hernia repair with a panniculectomy is the add-on E748A (\$122.05), not S332A (S36).                                                                                                   |
| <b>K036A,K070A,K730A,K738A</b> | A035A, A935A, A036A, A033A, A034A, C124A, C126A                             | Yes        | Paid on top of the visit: K036A to the specialist too (A60); K070A 'in addition to the assessment fee' (A58); K730A and K738A 'in addition to visits or other services' the same day (A42, A48). |
| <b>K708A,K709A,K121A</b>       | A035A, A935A, A036A, A033A, A034A, C032A, C122A, C123A, C124A, C126A, C121A | Yes        | Only services rendered during the conference are not paid; a visit outside it the same day is (A29 rule 8, A32 rule 4).                                                                          |
| <b>K708A</b>                   | K709A                                                                       | No         | Only one of K708A, K709A, K710A or K711A per physician per day (A29).                                                                                                                            |
| <b>C122A</b>                   | C124A, C126A, C032A                                                         | No         | One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).                                                                                              |
| <b>C142A,C143A</b>             | C124A, C126A                                                                | No         | C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP46).                                                                                                           |
| <b>C122A</b>                   | C142A                                                                       | No         | Only one of C122A or C142A per admission (GP46).                                                                                                                                                 |
| <b>C123A</b>                   | C143A                                                                       | No         | Only one of C123A or C143A per admission (GP46).                                                                                                                                                 |
| <b>E420A</b>                   | E409A, E410A                                                                | Yes        | E420A isn't applied to the after-hours premium, but the after-hours premium is still payable (GP109).                                                                                            |
| <b>E083A</b>                   | C038A                                                                       | No         | E083A is only for the MRP's own subsequent visits (GP47).                                                                                                                                        |
| <b>E083A</b>                   | C032A, C037A, C039A, C122A, C124A                                           | Yes        | The Schedule lists C032A, C037A and C039A as examples of visits E083A applies to (GP47).                                                                                                         |
| <b>E084A</b>                   | C032A, C122A, C123A, C124A                                                  | No         | E084A is only for MRPs in the specialties listed on GP47; General Surgery isn't one.                                                                                                             |

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026); pages in brackets. Totals are your fee only (suffix A): the surgical assistant bills the Asst units × \$12.91 and the anaesthetist the Ana units × \$15.96, plus time units, with suffix B or C (GP85, GP92). Totals leave out the 85% rule for a second procedure under the same anaesthetic (SP2 §3) unless you tick it, and any procedure entered outside the procedure list. Age premiums for patients under 16 on consults and surgery are added by OHIP on the remittance (GP64).

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