Haematology OHIP Billing Cheat Sheet 2026

OHIP specialty 61 · Chemotherapy or IV infusion · Weekly or monthly management · Procedure-only visit · Updated November 2026

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

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

Office consultation

A615A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same problem: 1 per 2 years.	$192.90
A655A	Limited consultation A real referral, but a narrow question that needed substantially less time than a full consult (GP19).	$118.05
A616A	Repeat consultation Same problem you consulted on before, another doctor cared for the patient in between, and a new written referral came in (GP19).	$118.05

- New written referral on a problem you consulted on before, after another doctor's care in between? Repeat consultation A616A pays $118.05, more than a re-assessment A614A ($72.00) or an assessment A613A ($95.95) (GP19).
- Haematology has no 75-minute comprehensive consult: A130A is only for internal medicine specialists (A129). Long consults stay A615A; stayed past 60 minutes with an unstable patient? Detention K001A can follow (GP29–30).
- Same patient, same diagnosis: 1 consultation per 2 consecutive 12-month periods. Extra ones are paid as an assessment, unless it's an in-patient or ED consult 12–24 months later (GP17).
- Decided on a bone marrow today and did it today? The consult and Z403A are both paid. Open the procedure panel (SP4).
- No written, signed referral with the referrer's billing number on file: paid as an assessment (GP16). E078A never goes on a consultation (GP25).

Office follow-up

A614A	Medical specific re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee (GP23).	$72.00
A611A	Complex re-assessment, letter to the family doctor Complex, obscure or serious condition. Send your findings in writing to the primary care physician or it is paid as a lesser fee (GP24). Limit: 4 per 12 months (shared with A613A).	$83.40
A613A	Full assessment of a new problem, no referral Full history of the presenting complaint and a detailed exam of the affected systems (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	$95.95
A618A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit (GP25).	$44.75

- Thalassaemia or sickle cell (282), haemophilia or other factor deficiency (286), ITP or other purpura (287): tick E078A for +50%. A614A becomes $108.00, A611A $125.10, A613A $143.93, A618A $67.13 (GP25–26).
- No E078A for iron deficiency (280), leukaemia, lymphoma or myeloma: those codes aren't on OHIP's list (GP26). Office or hospital out-patient clinic only, never ED, in-patient or LTC (GP25).
- Order to reach for: A611A ($83.40) when the case is complex and you write to the family doctor, then A614A ($72.00), then A618A ($44.75).
- A613A and A611A share a limit of 4 per patient per 12 months, and A614A is 2 per 12 months; past those OHIP pays a lesser fee, so a complex 3rd visit with a letter is better billed as A611A (GP23–24).
- Haemochromatosis or polycythaemia patient in only for a venesection? Bill G483A + G700A ($18.50) from the procedure-only tile, not an assessment (J3, J7).

Called to the ED

A615A	Consultation ED doctor's request on the chart; report back to them.	$192.90
A655A	Limited consultation Narrow question, much less time than a full consult (GP19).	$118.05
A613A	Full assessment, no consult request e.g. your own patient sent in to you.	$95.95
A614A	Re-assessment Your own patient you assessed recently.	$72.00
A618A	Quick look or advice	$44.75

- Not on ED duty when called? Bill your A-code plus the ED special visit premiums (travel and first patient seen). Evenings, weekends and nights pay more (A123, GP65, GP70).
- If you then admit the patient, this ED consult is your admission assessment: as MRP add E082A (+30%) (GP40, GP42).
- Sickle cell or thalassaemia patient on weekly G098A? Emergency visits and their premiums are paid on top of G098A (J49).
- Urgent plasma exchange or exchange transfusion started 17:00–07:00 or on a weekend: E409A (+50%) or E410A (+75% at night) adds to the procedure fee (GP103–GP104).
- Stayed with an unstable patient after the consult? Detention K001A ($21.10 per 15 min) starts after 60 minutes (GP29–30).

In-patient consult

C615A	Consultation, routine request Requested by the attending doctor; written report on the chart.	$192.90
C655A	Limited consultation Narrow question, much less time than a full consult.	$118.05
C616A	Repeat consultation Same problem after another doctor's care, new request.	$118.05
C613A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	$95.95
A615A	Called urgently to see another doctor's in-patient Non-elective call to the ward: bill A-prefix codes and the in-patient special visit premiums (A123, GP43).	$192.90

- Urgent call to the ward: bill A615A, not C615A, and add the special visit premiums for the time of day (A123, GP65).
- Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission; not for transfers within the hospital (GP42).
- Seen your patient for the same illness in the last 90 days? The admission assessment is a re-assessment (C614A, $72.00), not C613A (GP40).
- Marrow at the bedside: Z403A is paid on top of the consult when you decide on it at this visit (SP4).
- Seen in the ICU or CCU? Add C101A ($9.10) per patient, unless critical care team fees are billed (GP103).

Hospital rounds

C612A	Subsequent visit, first 5 weeks 1 a day. Weeks 6–13: C617A, 3 a week. After week 13: C619A, 6 a month (GP43).	$40.05
C122A	MRP visit, day after admission Once per admission. First visit after transfer out of ICU: C142A instead (GP44, GP46).	$71.80
C123A	MRP visit, 2nd day after admission Once per admission. After an ICU transfer: C143A (GP44, GP46).	$71.80
C124A	MRP, day of discharge Discharge summary within 48 h. Not if the stay was under 48 h (GP45).	$71.80
C126A	MRP, discharge of a complex patient Stay 7+ days, 3+ diagnoses that lengthened it, 45+ minutes of your time. Instead of C124A (A13).	$95.10
C618A	Concurrent care Family doctor stays MRP and asked you to keep directing care: 4 the first week, then 2 a week (GP48).	$40.05

- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays; haematology is on the E084A list. One per patient per day (GP47).
- C122A + E083A = $93.34 versus a plain C612A at $40.05: claim the MRP codes on days 1, 2 and discharge.
- Complex discharge (7+ day stay, 3+ diagnoses, 45+ minutes): C126A pays $95.10, $23.30 more than C124A (A13).
- After week 5, an acute intercurrent illness beyond the weekly limit is C121A ($40.05), outside the limits (GP43). Palliative care visits: C982A ($40.05) (GP50).
- Admitted transfusion-support or haemophilia patients: bill in-patient visits instead of the weekly G098A or G100A (J49–J50).

Chemotherapy or IV infusion

G381A	Standard IV chemotherapy Minor-toxicity agents needing physician monitoring, e.g. cyclophosphamide, methotrexate, fluorouracil, zoledronic acid (J57).	$54.50
G345A	Complex IV chemotherapy or biologic Can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicity, e.g. rituximab, anthracyclines, bortezomib, fludarabine (J57).	$75.00
G359A	Special IV chemotherapy Major toxicity, frequent monitoring, long administration, e.g. high-dose methotrexate, cytarabine > 2 g/m², ifosfamide with MESNA, a bispecific antibody (J57).	$105.15
G390A	Induction for acute leukaemia, myeloablation, CAR-T or bispecific step-up 1 per induction phase or myeloablative therapy, 1 per CAR-T infusion, up to 3 per bispecific initial dosing phase with high CRS risk (J58).	$262.40
G075A	Test dose (bleomycin, L-asparaginase) Once per patient per drug (J58).	$30.50
G389A	Gamma globulin (IVIG) prepared and infused Per patient per day (J55).	$13.90

- Pick the tier by the most toxic agent: G359A ($105.15) pays almost double G381A ($54.50). Rituximab and bortezomib are complex (G345A), not standard (J57).
- The chemotherapy fee includes every assessment by any physician for 24 hours after the treatment. An assessment before it at the same visit is paid (J3, J57).
- Venipuncture, the IV line and giving the drugs are included in G381A, G345A, G359A, G075A and G390A: don't add G489A or G379A (J57).
- Biologics count only if a monoclonal antibody or cytokine. Blood products, insulin and vaccines are not biologic agents for these codes (J57).
- G381A alone in your office? Add G700A ($8.80); it's a + procedure. Not in hospital (J3).

Weekly or monthly management

G098A	Transfusion support, per week Sickle cell disease, thalassaemia or transfusion-dependent congenital haemolytic anaemia: transfusions, iron chelation, overload monitoring, crisis care, counselling, phone advice for the week (J49).	$32.35
G100A	Home haemophilia infusion, per week Patient self-administering factor: clinic visits, infusion teaching, phone advice and counselling for the week (J50).	$32.35
G271A	Long-term anticoagulant supervision by phone, per month Ordering and reading tests, dose changes and phone advice, even when the patient calls (J8).	$13.10
G388A	Special oral chemotherapy started, this month Malignant disease; agent with early toxicity risk (e.g. imatinib, dasatinib, lenalidomide, thalidomide). Covers results review and all advice for 21 days; you're available 24 h after the start. Once per patient per month (J59).	$28.00
G382A	Monthly phone supervision of chemotherapy Malignant or autoimmune disease (J58). Not in a month with G388A (J59).	$13.95

- G098A and G100A include the routine out-patient visits for the week; don't bill A614A for them. Emergency visits and premiums are paid on top (J49–J50).
- Admitted? Bill the in-patient fees instead of G098A or G100A that week (J49–J50).
- G388A and G382A are not paid for the same patient in the same month: G388A ($28.00) pays double, so use it the month the oral agent starts (J59).
- Iron deficiency or acquired anaemia is not transfusion support: G098A is only for the three listed conditions (J49).
- Running an anticoagulation clinic in your office? A point-of-care prothrombin time G031A ($6.40) is billable with the result, your reading and the dose decision charted (J65, J67).

Procedure-only visit

- Venesection, venipuncture or an IV infusion was the only reason for the visit? Add G700A ($8.80) once; they're + procedures. Not in hospital (J3, J7, J55).
- Z403A is not a + procedure, so a marrow alone gets no G700A. Planned at an earlier visit: only a partial assessment A618A is paid before it that day (J3, SP4).
- Dry tap? Z403A isn't paid if no material is obtained for examination (R1). One Z403A covers aspirate and core together.
- Therapeutic plasma exchange: G277A ($82.00) for the first 5 in a year, then G278A ($41.80) (J9).
- Non-elective plasma exchange (G277A; G278A isn't on the list), exchange transfusion, IV start or marrow after hours: tick E409A (+50%) or E410A (+75%, 00:00–07:00) (GP103–GP104).

Counselling or family meeting

K013A	Counselling or education Booked visit only for advice and education, e.g. a new diagnosis or anticoagulation. First 3 units per patient per 12 months.	$80.00
K033A	Counselling, after the first 3 units this year	$56.30
K002A	Interview with relatives or substitute decision-maker Separately booked, about the patient's care, not only for consent. Billed on the patient's number (GP61).	$80.00
K015A	Counselling relatives of a dying patient Billed on the ill patient's number.	$80.00

- 20 minutes of K013A pays $80.00, more than A614A ($72.00). It must be pre-booked or it's paid as an assessment (GP58).
- With counselling no consult or assessment is paid the same day. Blood draws, injections, vaccines, K002A/K015A and your K730A call are allowed (GP58).
- Patients on weekly G098A or G100A: counselling for that week is already included (J49–J50).
- Start and stop times charted: 20 min = 1 unit, 46 = 2, 76 = 3 (GP54–GP55).

Video, phone or e-consult

A614A + K300A	Video re-assessment Full fee. Patient seen in person in the last 24 months, or consulted by video (A66).	$72.00
A614A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85% (A70).	$72.00
A611A + K301A	Phone complex re-assessment, letter to family doctor 85% of $83.40.	$83.40
A615A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	$192.90
K731A	Phone advice to the referring doctor or NP, 10+ min Start and stop times, reason and advice charted. Not to arrange a transfer, visit or test, or mainly to discuss results (A42–A44). Limit: 1 per patient per day.	$47.75
K739A	E-consultation reply through a secure server Opinion sent within 30 days (A48). Limit: 6 per patient per 12 months, 400 a year.	$20.50

- E078A still applies by video or phone for 282, 286 and 287 patients: 50% of the virtual fee (A74).
- A611A, A613A, A614A and A618A can be by phone or video; consults and in-patient C codes are video only (Appendix J).
- Video pays 100%, phone 85%: a video re-assessment is worth $10.80 more than the same call by phone.
- K731A and K739A aren't paid if you see the patient the same day or the next; put the referrer's billing number on the claim (A43, A49).

Also bill, if it's true

G521A	Life-threatening critical care, up to 15 min Vital organ failure with imminent risk of death. Time at the bedside or on the floor, no other patients meanwhile; start and stop times charted (J26–J27).	$125.10
G521A + G523A	Life-threatening critical care, 16–30 min First and second quarter hour (J26).	$189.60
G522A	Critical care, each further 15 min after 30 Tick with 16–30 min. 4th and later physicians tick G391A instead (J26).	$42.50
G395A	Other critical care (resuscitation), first 15 min Threat to life or limb that, without your resuscitation, would likely need life-threatening critical care or cost the limb. Not with G521A–G523A the same day (J28).	$64.70
G391A	Critical care, each further 15 min after G395A, or 4th+ physician Tick with G395A for each quarter hour after the first. 4th and later physicians on a life-threatening case bill G391A per 15 min instead of G521A–G523A (J26, J28).	$34.35
E078A	Chronic disease premium (+50%) Established diagnosis on OHIP's list, e.g. 282 thalassaemia or sickle cell, 286 haemophilia or other factor deficiency, 287 ITP or purpura, 042–044 HIV, or any other GP26 code such as 250 diabetes. Office or out-patient clinic only. That code goes on the claim (GP25–26).	+50%
E082A	I'm admitting as MRP: admission premium +30% of the admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	I'm the MRP, weekday +30% on subsequent visits by the MRP. One of E083A/E084A per patient per day (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A; haematology is an eligible specialty (GP47).	+45%
C101A	Patient is in the ICU or CCU Per patient seen. Not with critical care, ventilatory or comprehensive care team fees (GP103).	$9.10
K001A	Stayed with the patient: detention, per 15 min Active treatment or monitoring, after 60 min of a consult or assessment (40 for a re-assessment, 30 for A618A). Not for waiting (GP29–30).	$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	$80.00
G489A	Blood draw Adolescent or adult (J7).	$3.54
G372A	IM or SC injection with the visit e.g. B12, enoxaparin teaching dose. Each injection (J54).	$4.55
G590A	Flu shot	$8.80
G700A	A + procedure was the only reason for the visit Once per visit: venesection G483A, venipuncture G489A, IV G379A. Not Z403A. Not in hospital, not with a consult or assessment (J3).	$8.80
G700A	The infusion was the only reason for the visit G381A is a + procedure: add G700A once when no consult or assessment is billed. Not in hospital (J3).	$8.80
E409A	Non-elective procedure started 17:00–24:00 weekdays, or daytime or evening on a weekend or holiday Adds 50% to qualifying procedures only: plasma exchange G277A (not G278A), exchange transfusion G275A, IV G379A and non-elective surgical procedures such as Z403A. The total adds it to every ticked procedure, so leave non-qualifying ones (venesection, blood draw, INR, marrow reading) out of the premium. Not for ED physicians on shift (GP103–GP104).	+50%
E410A	Non-elective procedure started 00:00–07:00 Adds 75% to the same qualifying procedures (GP104).	+75%
A614A	Also re-assessed the patient before treatment Procedures are paid on top of an assessment (J3). Assessments in the 24 h after the chemotherapy are included in it (J57).	$72.00
A611A	Also did a complex re-assessment, letter to the family doctor Before treatment. 4 per 12 months with A613A (GP24, J57).	$83.40

A613A	Also did a full assessment of a new problem Before treatment. 1 per 12 months (GP23, J57).	$95.95
A618A	Also did a quick check before treatment Partial assessment, no yearly limit (GP25, J57).	$44.75
A614A	Also saw the patient today: re-assessment G271A, G388A and G382A are monthly supervision fees; an in-person visit is billed on its own. Not for G098A/G100A patients' routine visits (J49–J50).	$72.00
A611A	Also saw the patient today: complex re-assessment, letter to family doctor Written findings to the primary care physician (GP24).	$83.40
A618A	Also saw the patient today: quick look Partial assessment (GP25).	$44.75
K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a referral, transfer, visit or test, or mainly to discuss results. Max 1 per patient per day. Paid on top of the visit (A42–A43).	$37.05
K738A	Sent an e-consult to another doctor Secure e-consult service; paid once the other doctor answers within 30 days. 1 a day, 6 per patient per 12 months (A48–A49).	$16.45
K070A	Filled in a home care referral form You're the most responsible physician. Once per Ontario Health atHome admission. Paid on top of the visit (A58).	$34.75
K036A	Northern health travel grant form Paid to the specialist as well as the referring doctor (A60).	$10.25
K121A	Hospital case conference, per unit Pre-scheduled; the MRP plus 2 other physicians or regulated professionals; 10+ min about this patient. Units: 10, 16, 26, 36 min… Max 4 per patient per 12 months. A visit outside the conference is still paid (A31–A33).	$37.05

Did a procedure or test?

Z403A	Bone marrow aspiration and/or core biopsy One code for aspirate, core or both. Not paid if no material is obtained. Your own local or sedation isn't billed (R1, SP5).	$133.55
L802A	You read the marrow aspirate (Romanowsky stain) Only if you personally interpret the slides and chart the report; not when a pathologist reports the same marrow. Lab services must also meet Reg 552 rules (J60, J62, J64).	$64.45
L800A	You read a blood film (Romanowsky stain) Only if you personally interpret it and report; one reader per film. Special stain: L826A $16.05 (J60, J64).	$29.40
Z804A	Lumbar puncture, including intrathecal chemotherapy Includes any drug injected at the LP and image guidance (J83).	$150.00
G483A	Therapeutic venesection Haemochromatosis, polycythaemia. + procedure: G700A when the sole reason (J7).	$9.70
G277A	Therapeutic plasma exchange, first 5 this year Each. # fee: premises and staff not included (J9).	$82.00
G278A	Therapeutic plasma exchange, 6th or later this year Each (J9).	$41.80
G275A	Exchange transfusion e.g. sickle cell crisis (J9).	$205.45
G276A	Donor cell pheresis (platelets or leukocytes) (J9).	$15.35
Z425A	Bone marrow harvest from donor (team fee) Bill on the donor's Ontario health number; out-of-province donor on the recipient's (R1, SP8).	$506.75
Z426A	Marrow or stem cell infusion into recipient (team fee) (R1).	$62.55
Z404A	Splenic puncture and aspiration Not paid if no material is obtained (R1).	$100.45
G379A	IV infusion, e.g. cryoprecipitate Applies to cryoprecipitate infusion. Not into an established IV line; not with the chemotherapy codes (J55, J57).	$6.15
G031A	Prothrombin time (INR) in your office Own patient, own office; result, interpretation and decision charted (J65, J67).	$6.40
G481A	Haemoglobin or haematocrit in your office Any method or instrument (J67).	$1.37
G489A	Blood drawn in your office	$3.54
G373A	IM or SC injection was the only reason for the visit First injection; each more is G372A (J54).	$7.90

Can I bill these together?

Code	With	Together?	Why
G521A,G523A,G522A	G395A	No	G395A isn't paid with G521A, G522A or G523A the same day (J28).
G391A	G521A, G523A, G522A	No	G391A is either the 4th and later physicians' fee in place of G521A–G523A (J26), or the time after G395A, which isn't paid with G521A–G523A the same day (J28).
G521A,G523A,G522A	G211A, Z437A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters, drugs given, defibrillation and cardioversion are included in life-threatening critical care (J26).
G395A,G391A	G211A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters and drugs given are included in other critical care (J28).
G521A,G395A	A615A, A655A, A613A, A614A, A618A, C615A, C655A, C616A, C613A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and its time can't count twice (J27, J28).
G521A,G523A,G522A,G395A,G391A	G400A, G405A, G557A	No	Critical care time codes aren't paid the same day as a critical care or ventilatory support per diem (J27–J28).
A615A,A655A,A616A	A613A, A614A, A611A, A618A	No	Only one consultation or assessment is paid for the same visit (GP10).
E078A	A613A, A614A, A611A, A618A	Yes	E078A adds 50% to a medical specific assessment, re-assessment, complex re-assessment or partial assessment in the office or out-patient clinic, with a listed diagnosis (GP25–26).
E078A	A615A, A655A, A616A, C615A, C613A, C614A, C611A, C612A	No	E078A only adds to office or out-patient assessments, not consultations, in-patient, ED or LTC services (GP25).
Z403A	A615A, A613A, A614A, A611A	Sometimes	Paid on top when you decide on the marrow at this visit. If it was decided at a visit in the last 12 months, only a partial assessment is paid before it that day (SP4).
Z403A	A618A	Yes	A partial assessment by a specialist is payable before an independent operative procedure the same day (SP4).
G381A,G345A,G359A,G390A,G075A	A613A, A614A, A611A, A618A, C612A	Sometimes	An assessment before the treatment is paid (J3); assessments by any physician in the 24 hours after it are included (J57).
G381A,G345A,G359A,G390A,G075A	G489A, G379A	No	Venipuncture, the vascular access line and giving the agent are included in the chemotherapy fee (J57).
G388A	G382A	No	G388A isn't paid for the same patient in the same month as G382A (J59).
G098A,G100A	A613A, A614A, A611A, A618A, K013A, K033A	Sometimes	Routine out-patient visits, counselling and advice for the week are included; only emergency visits and their premiums are paid on top (J49–J50).
G098A,G100A	C612A, C122A, C123A, C124A, C615A, C613A	No	When the patient is admitted, in-patient fees are paid instead of G098A or G100A (J49–J50).
G700A	G483A, G489A, G379A, G381A	Yes	These are + procedures: add G700A once when one is the only reason for the visit, outside hospital (J3).
G700A	A615A, A655A, A616A, A613A, A614A, A611A, A618A	No	G700A is for a visit where a + procedure was the sole reason, not with a consultation or assessment (J3).
G700A	Z403A	Sometimes	Z403A is not a + procedure, so G700A needs a + procedure (e.g. venesection, venipuncture) as the sole reason for the visit (J3).
E409A,E410A	G277A, G275A, G379A, Z403A, Z404A	Sometimes	Only when the procedure is non-elective (or an elective case pushed into the period by an emergency) and you're not an ED physician on shift (GP103–GP104).

Code	With	Together?	Why
E409A,E410A	G483A, G489A, G031A, G481A, G276A, G278A, G373A, L800A, L802A	Sometimes	Both are paid, but E409A/E410A don't increase this code: it isn't on the GP104 list. The premium counts only the qualifying procedure, e.g. G277A or Z403A (GP104).
E409A	E410A	No	One after-hours premium per procedure: evening/weekend E409A or night E410A (GP104).
Z804A	G372A	Sometimes	Not for a drug given into the lumbar puncture: Z804A includes it, e.g. intrathecal chemotherapy. A separate IM or SC injection is still G372A (J83, J54).
G277A	G278A	Sometimes	G277A for the first 5 exchanges in a year, G278A from the 6th (J9).
G373A	A615A, A613A, A614A, A611A, A618A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A (J54).
K013A,K033A	A615A, A655A, A616A, A613A, A614A, A611A, A618A	No	With counselling no consultation or assessment is paid the same day (GP58).
K013A,K033A	K002A, K015A, G489A, G372A, G590A, K036A, K730A	Yes	These are on the list of services allowed with counselling (GP58).
K013A,K033A	K070A, K121A, K738A, G483A	No	With counselling only the services listed in GP58 are paid the same day; this isn't one of them (GP58).
K002A	A615A, A613A, A614A, A611A, A618A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A,K739A	A615A, A613A, A614A, A611A, A618A, C615A, K013A	No	Phone or e-consult isn't paid if you see the patient the same day or the next day; bill the visit (A43, A49).
K730A,K738A,K036A, K070A	A615A, A655A, A616A, A613A, A614A, A611A, A618A	Yes	Paid on top of the visit: K730A and K738A in addition to visits the same day (A42, A48), K070A with the assessment (A58), K036A to the specialist too (A60).
K121A	C615A, C613A, C614A, C612A, C122A, C123A, C124A, C126A, C618A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C618A, C615A, C613A	No	E083A/E084A only add to subsequent visits by the MRP, not consults or concurrent care (GP47–48).
E082A	C612A, C122A, C123A, C124A, C126A, E083A	No	E082A only adds to the MRP's admission assessment and no other service or premium (GP42).
C122A,C123A,C142A, C143A	C124A, C126A	No	C122A/C123A/C142A/C143A aren't paid the same day as the discharge visit (GP44, GP46).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C101A	G400A, G405A, G557A	No	C101A isn't paid with critical care, ventilatory or comprehensive care team fees (GP103).
K001A	A615A, A613A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–30).

From the Ontario Schedule of Benefits (effective July 1, 2026): Haematology listings A123–A124, General Preamble GP10–GP104, Diagnostic and Therapeutic Procedures (J3–J9, J49–J59, haematopathology J64), Haematic and Lymphatic Surgical Procedures (R1) and the Surgical Preamble (SP4). Haematology has no long-term care listing; the Schedule sends you to Internal Medicine for services it doesn't list (A123). Totals leave out the age premium on specialist consultations and procedures for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance. Phone visits are shown at the 85% OHIP pays; E078A on a virtual visit is 50% of the virtual fee. Check your remittance advice if a fee looks different.

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