Infectious Disease OHIP Billing Cheat Sheet 2026

OHIP specialty 46 · HIV care or counselling by time · Hospital follow-up visits · Home IV antibiotics (home care) · Updated November 2026

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

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

Office consultation

A465A	Consultation Written, signed referral on file; full assessment and a written report back to the referring doctor or NP (GP16). Limit: Same problem: 1 per 2 years. Unrelated problem: 1 per 12 months.	$205.90
A460A	Comprehensive consultation, 75+ minutes face to face All the elements of a consultation plus at least 75 minutes of direct contact. Time on separately billed procedures and chart, imaging or lab review doesn't count. Record start and stop times or it is paid as a lesser fee (A125).	$342.25
A275A	Limited consultation A real referral, but a narrow question that took much less time than a full consult (GP19).	$119.30
A466A	Repeat consultation Same problem you consulted on before, another doctor cared for the patient in between, and a new written referral came in (GP19).	$124.00

- Spent 75+ minutes face to face? A460A pays $342.25, $136.35 more than A465A. Chart the start and stop times or it drops to a lesser fee (A125).
- Same patient, same problem: 1 consultation per 2 consecutive 12-month periods, A460A included. A 2nd within the first 12 months is paid as an assessment. Exception: a 2nd consult 12 to 24 months later in hospital or the ED (GP17–18).
- Back with the same problem after another doctor treated them in between? Ask for a new referral and bill A466A ($124.00) instead of a re-assessment A464A ($82.10) (GP19).
- No written referral on file, or one asked for after the visit, means it is paid as an assessment. A referral from a medical trainee is paid as an assessment too (GP16, GP18).
- Phoned the medical officer of health right away about a listed disease (e.g. measles, invasive meningococcal disease, legionellosis, hepatitis A)? Tick K034A ($36.00) (A60).

Office follow-up

A464A	Re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	$82.10
A461A	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 A463A).	$95.05
A270A	Complex infectious disease assessment, 20+ min Ongoing care of active TB (not latent), active NTM disease (not colonization), a deep-seated fungal infection (not aspergilloma), or a multi-drug resistant organism on IV antibiotics or oral linezolid outside hospital that you supervise. All elements of a specific assessment; start and stop times charted (A125–A126). Limit: 6 per patient per 12 months.	$95.05
A463A	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).	$107.00
A468A	Quick look or advice History of the complaint, the exam needed, advice, chart note (GP25). No yearly limit.	$62.15

- HIV (dx 042, 043, 044) or another chronic disease on the GP26 list: tick E078A for +50%. A464A becomes $123.15, A461A $142.58, A463A $160.50, A468A $93.23. Office or hospital out-patient clinic only, not the ED, in-patients or LTC (GP25–26).
- Active TB, NTM disease, deep fungal infection or a resistant organism on outpatient IV therapy: A270A ($95.05) pays $12.95 more than A464A and needs no letter, so A461A's 4-a-year limit stays free. 6 a year, then a lesser fee (A126).
- E078A doesn't go on A270A: it is not a medical specific assessment, re-assessment or partial assessment (GP25).
- Order to reach for without E078A: A270A if it qualifies, then A461A ($95.05) when complex and you send a letter, then A464A ($82.10), then A468A ($62.15).
- A464A is 2 per 12 months (hospital admissions don't count); A463A and A461A share 4 per 12 months. Over a limit, OHIP pays a lesser fee (GP23–24).

HIV care or counselling by time

K022A	HIV primary care Any specialty may bill it. Counselling time rules: 20 min = 1 unit, 46 = 2, 76 = 3 (A50, GP9, GP55).	$80.00
K013A	Counselling or education Booked visit only for advice and education. First 3 units per patient per 12 months (GP58).	$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 catastrophically or terminally ill patient Billed on the ill patient's number (GP60).	$80.00

- HIV follow-up under 46 minutes? Your own A464A + E078A pays $123.15 (A468A + E078A $93.23), more than 1 unit of K022A ($80.00). From 46 minutes K022A pays $160.00, from 76 minutes $240.00 (A50, GP25–26, GP55).
- Bill any other consultation or visit for the patient that day and K022A is included in it, not paid on top (A50).
- With counselling, no consult or assessment the same day. Shots, blood draws and K002A/K015A are allowed (GP58).
- Time units need consecutive face-to-face time with start and stop times charted. Time on other billed services and chart review doesn't count (GP55).
- K022A, K013A, K033A, K002A and K015A can be done by video (100%) or phone (85%) (Appendix J, A70).

Called to the ED

A465A	Consultation ED doctor's request on the chart; report back to them.	$205.90
A460A	Comprehensive consultation, 75+ minutes face to face Record start and stop times (A125).	$342.25
A463A	Full assessment, no consult request e.g. your own patient sent in to you.	$107.00
A464A	Re-assessment Your own patient you assessed recently.	$82.10
A468A	Quick look or advice	$62.15

- Not on ED duty when called? Use the A-codes plus the ED special visit premiums (K960A travel, K990A–K999A person seen). Never with H-codes (A126, GP65, GP70).
- If you then admit the patient, this ED consult or assessment is the admission assessment: don't bill a second one. As MRP, add E082A (+30%) to it (GP40, GP42).
- A 2nd consult for the same problem 12 to 24 months after the first is still paid as a consult in the ED or in hospital (GP17).
- Stayed with the patient for active treatment or monitoring? Detention K001A ($21.10 per 15 min) starts after 60 minutes of a consult or assessment, 120 of A460A. Not for waiting (GP30–31).
- No E078A in the ED (GP25).

In-patient consult

C465A	Consultation Requested by the attending doctor; written report on the chart.	$205.90
C460A	Comprehensive consultation, 75+ minutes face to face Same conditions as A460A: start and stop times charted (A126).	$342.25
C275A	Limited consultation Narrow question, much less time than a full consult.	$119.30
C466A	Repeat consultation Same problem after another doctor's care, new request.	$124.00
C463A	Admission or full assessment, no consult Your own patient you admit, not assessed for this illness in the last 90 days (GP40).	$107.00
C464A	Admission re-assessment You admit a patient you assessed for the same illness in the last 90 days (GP40).	$82.10
A465A	Called urgently to see another doctor's in-patient Emergency call to the ward: bill A-prefix codes and the in-patient special visit premiums (GP43).	$205.90

- 75+ minutes face to face on a complicated in-patient? C460A pays $342.25 instead of $205.90 (A126).
- Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission. Not for transfers within the hospital, and not if the hospital pays you for in-patient work without reducing it (GP42).
- Seeing patients in the ICU or CCU: add C101A ($9.10) per patient, unless critical care team fees are billed (GP103).

- Called in urgently from outside to another doctor's patient? Bill A465A, not C465A, plus the in-patient special visit premiums; chart the time of the visit (GP43, GP69).
- Only one consultation or assessment per admission when a patient is transferred between physicians in the same hospital (GP40).

Hospital follow-up visits

C462A	Subsequent visit Weeks 1–5: 1 a day. Weeks 6–13: C467A, 3 a week. After week 13: C469A, 6 a month. Each specialist following a shared patient bills subsequent visits (GP43).	$40.05
C468A	Concurrent care The family physician stays MRP and asked you to keep directing care. 4 in the first week, then 2 a week (GP48).	$40.05
C122A	MRP visit, day after admission You are the MRP. Once per admission (GP44).	$71.80
C123A	MRP visit, 2nd day after admission Once per admission (GP44).	$71.80
C142A	MRP, 1st visit after transfer out of ICU Patient was getting critical, ventilatory or comprehensive care, not just monitoring. Replaces C122A (GP46).	$71.80
C124A	MRP, day of discharge Discharge summary within 48 h (reason, procedures, diagnosis, meds). 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
C121A	Extra visit for an acute intercurrent illness After 5 weeks, beyond the weekly or monthly limits (GP43).	$40.05

- Following another service's patient because the case needs several disciplines? Each of your visits is a subsequent visit, C462A, 1 a day for the first 5 weeks. Concurrent care C468A is only when the family physician is MRP, and is capped at 4 the first week and 2 a week after (GP43, GP48).
- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays. Infectious disease is on the E084A list. One per patient per day (GP47).
- C122A + E083A = $93.34 versus a plain C462A at $40.05: claim the MRP codes on days 1, 2 and discharge when you are MRP (GP44).
- Complex discharge (7+ day stay, 3+ diagnoses, 45+ minutes): C126A pays $95.10, $23.30 more than C124A (A13).
- Inpatient visit limits count from the day you first saw the patient when they were referred to you in hospital (GP43).

Home IV antibiotics (home care)

K071A	Advice to home care staff, first 8 weeks You personally gave medical advice or direction to Ontario Health atHome (or contractor) staff. Date, advice and the staff member's name charted (A59). Limit: 1 per week per physician, 2 per patient per week.	$21.95
K072A	Advice to home care staff, after week 8 Same requirements as K071A (A59). Limit: 2 per month per physician, 4 per patient per month.	$21.95
K070A	Filled in the home care referral form You are the most responsible physician for the patient's ongoing care. Once per home care admission; not if they are already on home care (A58–A59).	$34.75

- Home care supervision on a day you also see the patient pays nil: bill the visit, and claim K071A or K072A on days without one (A59).
- The referral form K070A is paid on top of the visit where you fill it in (A58).
- At the clinic visit, a patient with a resistant organism (e.g. MRSA, VRE, ESBL, CPE) on IV antibiotics or oral linezolid that you supervise qualifies for A270A ($95.05) (A125).
- Giving a dose into an IV line that is already in place isn't billable. Only G381A is paid that way (J55).

Shot or procedure only

- Procedure or vaccine was the only reason for the visit? Add G700A ($8.80) once per visit when at least one is marked (+), e.g. vaccines, G379A, G370A. Not in hospital (J3).
- Injection alone: G373A ($7.90) for the first, G372A ($4.55) each further one. With a visit, every injection is G372A (J54).
- Penicillin allergy skin test: G196A ($17.00, 3 per 12 months); outside hospital add E582A ($32.20) when testing with the minor determinant mixture (J5).

Advice to another doctor

K731A	Phone call with the referring doctor or NP, 10+ minutes Patient-related discussion; chart start/stop times, reason and your advice (A43–A44). Limit: 1 per patient per day.	$47.75
K739A	E-consultation through a secure server Opinion sent within 30 days (A48). Limit: 6 per patient per 12 months, 400 a year.	$20.50
K733A	Call arranged by CritiCall Ontario Referrer and patient in Ontario (A45–A46). Limit: 1 per patient per day.	$47.75
K735A	Phone consult while you're on ED duty Use instead of K731A when you're on shift in an ED or urgent care clinic (A42–A43).	$47.75

- Put the referring doctor's or NP's billing number on the claim or it isn't paid (A44, A47, A50).
- K731A, K735A and K739A aren't paid if you see the patient (consult, assessment or K time code) the same day or the next day: bill the visit instead (A43, A49).
- K731A and K739A aren't paid when the call is to arrange a transfer, a visit or a test, or mainly to discuss results. A CritiCall call (K733A) may be about a transfer (A43, A45).

Phone or video

A465A + K300A	Video consultation Consultations (A465A, A460A, A275A, A466A) are video only, never phone (Appendix J).	$205.90
A464A + K300A	Video re-assessment Full fee.	$82.10
A464A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	$82.10
A270A + K301A	Phone complex infectious disease assessment Same conditions as in person: 20+ min, start and stop times. 85% of $95.05.	$95.05
A461A + K301A	Phone complex re-assessment, letter to family doctor 85% of $95.05.	$95.05
A468A + K301A	Phone quick follow-up 85% of $62.15.	$62.15

- E078A (+50%) still applies by video or phone, on 50% of what is paid for the virtual visit: A464A by phone + E078A = $104.68 (A74).
- Video pays 100%, phone 85%. A video re-assessment is worth $12.32 more than the same call by phone (A70).
- Patient must have seen you in person in the last 24 months, or had a video consult with you (A66).
- The patient (or a needed follow-up) must start it. Check-in calls and normal results aren't billable. Record phone or video in the chart (A68).
- In-patient C-codes (e.g. C465A, C463A) are on the video-only list, and only when you aren't the MRP and the hospital has no local physician with your expertise (Appendix J, A69).

Long-term care

W465A	Consultation in LTC or chronic care Written request from the attending doctor.	$205.90
W460A	Comprehensive consultation, 75+ minutes face to face Same conditions as A460A (A127).	$342.25
W275A	Limited consultation	$119.30
W466A	Repeat consultation	$124.00
W292A	Admission assessment, you're the attending Type 1: general assessment on admission. Saw them before admission (consult or general assessment)? Type 2 W294A $20.60. Re-admitted after 3+ days elsewhere: Type 3 W297A $30.70 (GP49).	$69.35
W299A	Periodic health visit Nursing home general re-assessment W464A ($20.60) only 6 months after it (A128).	$65.05
W462A	Chronic care hospital visit First 4 a month; then W461A (max 6 a month). Palliative care visits: W982A (A128).	$40.05
W463A	Nursing home visit First 2 a month; then W468A (max 3 a month). Palliative care visits: W972A (A128).	$40.05
W121A	Visit for an acute intercurrent illness Paid whenever needed, whether or not the monthly limit is reached (GP49).	$40.05
A465A	Called in urgently (non-elective) A-prefix code with the LTC special visit premiums. Not for routine residents seen on the same trip (GP66).	$205.90

- Special visit premiums never apply to elective LTC visits, even though LTC is the resident's home (GP66).
- Already in the home and asked to see another doctor's resident urgently: bill A-prefix codes (GP49).
- Discharge after a 30+ day stay to another facility or home where a different provider takes over, with follow-up in the summary: W124A $71.80. Not for respite stays (A20).
- No E078A in LTC (GP25).

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	HIV or another chronic disease on the GP26 list +50%. Office or out-patient clinic only (also by video or phone); diagnosis established and on the claim (042, 043, 044 for HIV). Not with A270A (GP25–26, A74).	+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 and C121A–C143A. One of E083A/E084A per patient per day (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A (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 to the exclusion of other work, after 60 min of a consult or A463A (120 for A460A, 40 for a re-assessment, 30 for A468A). Not for waiting; paid on review (GP29–31).	$21.10
K034A	Phoned a reportable disease to the medical officer of health Listed diseases only (e.g. measles, invasive meningococcal or group A strep disease, legionellosis, listeriosis, hepatitis A, typhoid). By you, right away; once per disease per patient per 12 months (A60).	$36.00
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 Through a secure e-consult service; paid once the other doctor answers within 30 days. Max 1 a day and 6 per patient per 12 months. Paid on top of the visit (A48).	$16.45
K070A	Filled in a home care referral form You're the most responsible physician and give ongoing care. Once per Ontario Health atHome admission; not if they're already on home care. Paid on top of the visit (A58–A59).	$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. Nothing else you do during the conference is paid (A31–A33).	$37.05
G489A	Blood draw (adolescent or adult) Child G482A $7.35, infant G480A $9.90 (J7).	$3.54
G372A	Injection with the visit Each intramuscular, subcutaneous or intradermal injection (J54).	$4.55
G590A	Flu shot (J54).	$8.80
K300A	Done by video Paid 100%. Patient asked for it; modality charted (A68, A70).	

K301A	Done by phone OHIP pays 85%; the total shows what is paid (A70).	
G700A	Procedure was the only reason for the visit Once per visit, with a procedure marked (+). Not in hospital (J3).	$8.80

Did a procedure, test or shot?

G482A	Blood draw, child Infant G480A $9.90 (J7).	$7.35
G379A	IV injection or infusion started Child, adolescent or adult. Not for doses into an IV already in place (J55).	$6.15
G373A	Injection was the only reason for the visit First injection; each further one G372A $4.55. Not with a visit (J54).	$7.90
G842A	Hepatitis B vaccine (J54).	$8.80
G843A	HPV vaccine (J54).	$8.80
G846A	Pneumococcal conjugate vaccine (J54).	$8.80
G847A	Tdap vaccine, adult (J54).	$8.80
G848A	Varicella vaccine (J54).	$8.80
G538A	Other vaccine not listed (J54).	$8.80
G593A	COVID-19 vaccine (J54).	$13.00
G369A	BCG inoculation after tuberculin testing (J53).	$5.30
G196A	Drug hypersensitivity skin test (e.g. penicillin) Validated drugs or agents, not foods or inhalants. Max 3 per patient per 12 months (J5).	$17.00
G196A + E582A	Penicillin skin test with minor determinant mixture, outside hospital E582A adds $32.20 to G196A (J5).	$49.20
G208A	Drug provocation (challenge) testing in the office, per hour Unit = 1 hour or major part. Max 5 sessions per 12 months (J4).	$21.90
G190A	Drug provocation testing in hospital, anaphylaxis likely Documented history makes a reaction likely; you attend directly throughout (J5).	$184.95
G185A	Drug desensitisation in hospital Significant risk of life-threatening anaphylaxis, full resuscitation equipment at hand, direct and ongoing attendance (J4).	$184.95
G200A	Acute desensitisation (e.g. penicillin) (J4).	$8.65
G370A + E542A	Joint, bursa or tendon sheath aspiration, outside hospital In hospital G370A alone $20.25. One code per joint (J53).	$32.90
G328A + E542A	Complex joint aspiration (not a normal knee), outside hospital In hospital G328A alone $39.80. Not for injection alone (J53).	$52.45
Z804A	Lumbar puncture Includes medication given and image guidance if used (J83).	$150.00
Z101A + E542A	Drained a subcutaneous abscess, local, outside hospital One abscess. In hospital Z101A alone $28.20 (M1).	$40.85
Z113A	Skin biopsy, no stitches Any method. With stitches Z116A, plus E542A outside hospital: $45.10 (M1).	$32.45

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	A465A, A460A, A463A, A464A, A468A, C465A, C460A, C275A, C466A, C463A, C464A	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).
A465A	A463A, A464A, A461A, A468A, A270A, A275A, A466A	No	A consultation already includes the assessment; bill one or the other for the visit (GP16).
A460A	A465A, A463A, A464A, A461A, A468A, A270A	No	A460A replaces A465A when you spent 75+ minutes; it must include all the elements of a consultation (A125, GP16).
C460A	C465A, C463A, C464A, C461A	No	One consultation or assessment per visit; C460A replaces C465A when 75+ minutes (A126).
C465A	C463A, C464A, C461A, C275A, C466A	No	A consultation already includes the assessment (GP16).
A270A	A463A, A464A, A461A, A468A	No	A270A is itself the assessment and must include all the elements of a specific assessment; bill one (A126).
E078A	A270A, C270A	No	E078A goes only on a medical specific assessment, re-assessment, complex re-assessment or partial assessment; A270A is none of these (GP25).
E078A	A465A, A460A, A275A, A466A, C465A, C460A, W465A, W460A	No	E078A is not paid on consultations, only on the assessments listed in GP25 (GP25).
E078A	C463A, C464A, C461A, C462A, W462A, W463A	No	E078A is only for the office or a hospital out-patient clinic, not in-patients, LTC or the ED (GP25).
E078A	A463A, A464A, A461A, A468A	Sometimes	Paid in the office or out-patient clinic when the chronic disease is established and its GP26 diagnostic code (e.g. 042, 043, 044 for HIV) is on the claim (GP25–26).
K022A	A465A, A460A, A275A, A466A, A463A, A464A, A461A, A468A, A270A	No	When you bill another consultation or visit for the patient the same day, K022A is included in it (A50).
K022A	E078A	No	E078A is a premium on an assessment; it isn't added to K022A (GP25).
K071A,K072A	A465A, A460A, A275A, A466A, A463A, A464A, A461A, A468A, A270A	No	Home care supervision on the same day as a consultation or visit with the same patient pays nil (A59).
K070A	A465A, A460A, A275A, A466A, A463A, A464A, A461A, A468A, A270A, C465A, C463A, C462A, C124A, C126A	Yes	Paid in addition to the assessment, by the most responsible physician (A58).

Code	With	Together?	Why
K034A,K036A	A465A, A460A, A275A, A466A, A463A, A464A, A461A, A468A, A270A, C465A, C460A, C463A, C464A, C462A, C468A, W465A, W462A, W463A	Yes	The Schedule lists no same-day restriction for K034A or K036A with a visit (A60).
K730A,K738A	A465A, A460A, A275A, A466A, A463A, A464A, A461A, A468A, A270A, C465A, C462A, C468A	Yes	Your own phone or e-consult to another doctor, as the referring physician, is paid in addition to visits the same day (A42, A48).
K731A,K739A	A465A, A460A, A463A, A464A, A461A, A468A, A270A, C465A, K022A, K013A	No	Your phone or e-consult advice isn't paid if you see the patient the same day or the next day; bill the visit (A43, A49).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C468A	No	MRP premiums only go on visits by the MRP; concurrent care means the family physician is MRP (GP47–48).
E082A	C462A, C468A, C122A, C124A	No	E082A goes only on the admission assessment and no other service (GP42).
C122A,C123A,C142A, C143A	C124A, C126A	No	C122A, C123A, C142A and C143A aren't paid the same day as the discharge visit (GP44, GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP44, GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP44, GP46).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C101A	C465A, C460A, C463A, C462A, C468A	Yes	C101A is added for each patient seen on a visit to the ICU or CCU, unless team fees are billed (GP103).
K001A	A465A, A463A, A270A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–30).
K001A	A460A	Sometimes	After a comprehensive infectious disease consultation, detention starts only past 120 minutes (GP31).
K001A	A464A	Sometimes	After a re-assessment, detention starts past 40 minutes (GP30).
K001A	A468A, C462A	Sometimes	After a partial assessment or subsequent hospital visit, detention starts past 30 minutes (GP30).
E582A	G196A	Yes	E582A is added to G196A when testing with penicillin minor determinant mixture outside a hospital (J5).
G370A	G328A	Sometimes	Only one of G370A, G371A, G328A or G329A per joint or bursa; both are paid only for different joints (J53).
W464A	W299A	Sometimes	The nursing home general re-assessment is only claimed 6 months after the periodic health visit (A128).

From the Ontario Schedule of Benefits (effective July 1, 2026): Infectious Disease listings A125–A128, Family Practice & Practice in General listings any specialty may bill (A42–A60), General Preamble GP9–GP103, Diagnostic and Therapeutic Procedures and Appendix J. Totals leave out the age premium on specialist consultations for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance. Phone visits are shown at the 85% OHIP pays. 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.