

Internal Medicine OHIP Billing Cheat Sheet 2026

OHIP specialty 13 · Diabetes yearly management · Counselling or interview · Advice to another doctor · Updated October 2026

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

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

Office consultation

A135A	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. Unrelated problem: 1 per 12 months.	\$192.85
A130A	Comprehensive consultation, 75+ minutes face to face All the elements of a consultation plus at least 75 minutes of direct contact. Record start and stop times or it is paid as a lesser fee. Time spent on separately billed procedures and chart or imaging review does not count (A129).	\$342.25
A435A	Limited consultation A real referral, but a narrow question that took much less time than a full consult (GP19).	\$123.10
A136A	Repeat consultation Same problem you consulted on before, the patient was cared for by another doctor in between, and a new written referral came in (GP19).	\$123.10

- Spent 75+ minutes face to face? A130A pays \$342.25, \$149.40 more than A135A. Chart the start and stop times or it drops to a lesser fee (A129).
- Same patient, same problem: only 1 consultation per 2 consecutive 12-month periods. 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).
- Back with the same problem after another doctor treated them in between? Ask for a new referral and bill the repeat consult A136A (\$123.10) instead of a re-assessment A134A (\$72.00) (GP19).
- No written referral on file, or one requested after the visit, means it is paid as an assessment (GP16).
- Referral from a medical trainee is paid as an assessment, not a consult (GP18).

Office follow-up

A134A	Re-assessment Full history of the problem and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	\$72.00
A131A	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 A133A).	\$83.40
A133A	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
A138A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit.	\$44.75
A120A	Assessment on the day of a colonoscopy Only when any doctor did the major pre-op visit in the last 12 months; then it is the only assessment paid that day (A129).	\$18.85

- Order to reach for: A131A (\$83.40) when the problem is complex and you send a letter, then A134A (\$72.00), then A138A (\$44.75).
- A133A and A131A share a limit of 4 per patient per 12 months; extras are paid as a lesser fee (GP23–24).
- A134A is 2 per 12 months (hospital admissions don't count). The 3rd is paid as a lesser fee, so a complex 3rd visit with a letter is better billed as A131A (GP23).
- Internal medicine has no chronic disease premium (E078A is not paid to specialty 13, GP25). Diabetes patients: the yearly K045A (\$80.25) or K046A (\$127.20) has no same-day rule, so tick it on the visit where the 12 months of care are complete (A99–A100).
- Spent 20+ minutes only counselling? Pick Counselling or interview: K013A pays \$80 per unit, more than A134A.

Called to the ED

A135A	Consultation ED doctor's request on the chart; report back to them.	\$192.85
A130A	Comprehensive consultation, 75+ minutes face to face Record start and stop times.	\$342.25
A133A	Full assessment, no consult request e.g. your own patient sent in to you.	\$95.95
A134A	Re-assessment Your own patient you assessed recently.	\$72.00
A138A	Quick look or advice	\$44.75
- If you then admit the patient, this ED consult is the admission assessment: don't bill a second one. As MRP, add E082A (+30%) to it (GP40, GP42). - Not on ED duty when called? Bill your A-code plus the ED special visit premiums (K960A travel, K990A–K999A person seen). Never with H-codes (GP65, GP70). - A 2nd consult for the same problem 12 to 24 months after the first is still paid as a consult when it's in the ED or in hospital (GP17). - Stayed with an unstable patient? Detention K001A (\$21.10 per 15 min) starts after 60 minutes of a consult or 120 of A130A (GP30–31). - Vital organ failure (shock, respiratory failure)? Life-threatening critical care: G521A \$125.10 first 15 min, G523A \$64.50 the second, G522A \$42.50 each 15 min after. Only time at the bedside or on the patient's floor, start and stop times charted; lines, intubation and blood gases are included (J26–J27).		

In-patient consult

C135A	Consultation Requested by the attending doctor; written report on the chart.	\$192.85
C130A	Comprehensive consultation, 75+ minutes face to face Same conditions as A130A: start and stop times charted.	\$342.25
C435A	Limited consultation Narrow question, much less time than a full consult.	\$123.10
C136A	Repeat consultation Same problem after another doctor's care, new request.	\$123.10
C133A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	\$95.95
A135A	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).	\$192.85
- 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). - Seen your patient for the same illness in the last 90 days? The admission assessment is a re-assessment (C134A, \$72.00), not C133A (GP40). - Transferred to you within the hospital: no new admission assessment; start with subsequent visits (GP40). - Seeing patients in the ICU or CCU: add C101A (\$9.10) per patient, unless critical care team fees are billed (GP103). - Running the ICU for a critically ill patient? Bill the daily team fee instead of visits: comprehensive care G557A \$429.30 day 1 (G558A, G559A later), critical care G400A \$223.10, ventilatory support G405A \$183.80. Not for stable or monitoring-only patients (J30–J32).		

Hospital rounds

C122A	MRP visit, day after admission Once per admission (GP44).	\$71.80
C123A	MRP visit, 2nd day after admission Once per admission.	\$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
C132A	Subsequent visit Weeks 1–5: 1 a day. Weeks 6–13: C137A, 3 a week. After week 13: C139A, 6 a month (GP43).	\$40.05
C124A	MRP, day of discharge Discharge summary within 48 h (reason, procedures, diagnosis, meds). Not if stay 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
- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays. One per patient per day (GP47). - C122A + E083A = \$93.34 versus a plain C132A 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).
- Consulting while the family doctor stays MRP? That's concurrent care C138A (\$40.05): 4 the first week, then 2 a week, no E083A (GP48). High-volume MRPs get the 17% hospitalist premium automatically (GP103).

Diabetes yearly management

K045A	Diabetes management by a specialist You're most responsible for the diabetes; flow sheet covers the last 12 months: lipids, A1C, BP, weight/BMI, meds, ACR, vaccines offered, eye referral offered, foot and neuro exam (A99). Limit: 1 per 12 months.	\$80.25
K046A	Diabetes team management with your own CDE A Certified Diabetes Educator you employ is on the team; document what the CDE did (A100). Limit: 1 per 12 months.	\$127.20

- Both need 4+ consults, assessments or K013A/K033A/K029A/K002A/K003A visits with this patient in the 12 months, and more than 100 diabetes patients a year (A99–A100).
- Bill only once the 12 months of required elements are done. Virtual visits count toward the 4 (A75).
- Insulin by phone: G500A (\$31.80) in the month insulin starts (2 per lifetime), then G514A (\$10.60, 1–3 contacts) or G520A (\$21.20, 4+) each month. Not for contacts on the same day as a visit (J42).

Counselling or interview

K013A	Counselling or education Booked visit only for advice and education. 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.	\$80.00
K015A	Counselling relatives of a dying patient Billed on the ill patient's number.	\$80.00

- Counselling is open to every specialty (GP9). 20 minutes of K013A pays \$80, more than A134A (\$72.00).
- With counselling, no consult or assessment the same day. Shots, blood draws, K002A/K015A, the MTO report K035A, the LTC form K038A, the travel grant form K036A and your own phone call for advice K730A are allowed; case conferences and the home care form are not (GP58).
- Must be booked as its own appointment and start/stop times charted: 20 min = 1 unit, 46 = 2, 76 = 3 (GP54, GP58).

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 CitiCall Ontario Patient and referrer in Ontario (A45).	\$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.	\$47.75

- Put the referring doctor's or NP's billing number on the claim or it isn't paid.
- Not 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).
- Not paid when the call is to arrange a transfer, a visit or a test, or mainly to discuss results.

Phone or video

A135A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	\$192.85
A134A + K300A	Video re-assessment Full fee.	\$72.00
A134A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	\$72.00
A131A + K301A	Phone complex re-assessment, letter to family doctor 85% of \$83.40.	\$83.40
A138A + K301A	Phone quick follow-up 85% of \$44.75.	\$44.75

- Video pays 100%, phone 85%. A 20-minute video re-assessment is worth \$10.80 more than the same call by phone.

- 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.
- In-patient codes (C-prefix) by video only when you're not the MRP and no local doctor with your expertise is available (A69).

Long-term care

W235A	Consultation in LTC or chronic care Written request from the attending doctor.	\$192.85
W435A	Limited consultation	\$123.10
W232A	Admission assessment, you're the attending Type 1: general assessment on admission. Saw them before admission (consult or general assessment)? Type 2 W234A \$20.60. Re-admitted after 3+ days elsewhere: Type 3 W237A \$30.70 (GP49).	\$69.35
W239A	Periodic health visit Periodic full check of a resident you attend. The nursing home general re-assessment W134A (\$20.60) only 6 months after it (A131).	\$65.05
W132A	Chronic care hospital visit First 4 a month; then W131A, up to 6 more. Palliative care visits: W982A (GP50).	\$40.05
W133A	Nursing home visit First 2 a month; then W138A, up to 3 more. Palliative care visits: W972A (GP50).	\$40.05
W121A	Extra visit for an intercurrent illness Outside the monthly limits (GP49).	\$40.05
A135A	Called in urgently (non-elective) A-prefix code with the LTC special visit premiums. Not for routine residents seen on the same trip (GP66).	\$192.85

- 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).
- Palliative care visits as MRP: W982A in chronic care, W972A in a nursing home, \$40.05 each. Designated palliative care bed: C982A (GP50, A131).
- 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).

Also bill, if it's true

A130A	Also saw the patient: comprehensive consultation, 75+ minutes face to face Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$342.25
A435A	Also saw the patient: limited consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$123.10
A136A	Also saw the patient: repeat consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$123.10
A120A	Also saw the patient: assessment on the day of a colonoscopy Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$18.85
A134A	Also saw the patient: re-assessment K045A and K046A are yearly management fees with no same-day rule, so the visit is paid on top (A99–A100).	\$72.00
A131A	Also saw the patient: complex re-assessment, letter to the family doctor K045A and K046A are yearly management fees with no same-day rule, so the visit is paid on top (A99–A100).	\$83.40
A133A	Also saw the patient: full assessment of a new problem, no referral K045A and K046A are yearly management fees with no same-day rule, so the visit is paid on top (A99–A100).	\$95.95
A138A	Also saw the patient: quick look or advice K045A and K046A are yearly management fees with no same-day rule, so the visit is paid on top (A99–A100).	\$44.75
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 or ventilatory 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 (120 for A130A, 40 for a re-assessment, 30 for A138A). Not for waiting (GP29–31).	\$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	\$80.00
A135A	Also saw the patient: consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$192.85
A133A	Also saw the patient: full assessment of a new problem, no referral Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$95.95
A134A	Also saw the patient: re-assessment Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$72.00
A131A	Also saw the patient: complex re-assessment, letter to the family doctor Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$83.40
A138A	Also saw the patient: quick look or advice Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$44.75
G500A	Insulin started this month (phone/advice contacts) 2 or more injections a day or pump. 2 per lifetime (J42).	\$31.80
G514A	Insulin management this month, 1–3 contacts Dose change needed; dated note of each contact (J42).	\$10.60
G520A	Insulin management this month, 4+ contacts One of G500A/G514A/G520A per patient per month (J42).	\$21.20
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 bill G391A \$34.35 per 15 min instead (J26).	\$42.50
G489A	Blood draw	\$3.54
G372A	Injection with the visit Each injection.	\$4.55
G590A	Flu shot	\$8.80
K045A	Yearly diabetes management fee is due today You're most responsible for the diabetes; 4+ visits with you in the 12 months; 100+ diabetes patients a year; flow sheet complete for the 12 months. 1 per 12 months. No same-day rule (A99).	\$80.25
K046A	Yearly diabetes team fee (your own CDE) is due today Same conditions as K045A, plus a Certified Diabetes Educator you employ, with their work documented. 1 per 12 months (A100).	\$127.20
K035A	Reported a medical condition to the MTO (driving) e.g. seizure, syncope, hypoglycemia, sleep apnea. More than one a year for the patient: submit with the manual review indicator. Paid on top of the visit (A59).	\$36.25
K036A	Northern health travel grant form Paid to the specialist as well as the referring doctor (A60).	\$10.25
K038A	Long-term care health assessment form For a patient applying for admission to long-term care, sent to Ontario Health atHome. Paid on top of the visit (A60).	\$46.35
K034A	Phoned a reportable disease to the medical officer of health Listed diseases only (e.g. legionellosis, invasive group A strep, meningococcal disease, listeriosis); 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–A49).	\$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
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. Today's visit is still paid if it wasn't during the conference (A31–A33).	\$37.05
K124A	Long-term care case conference, per unit Pre-scheduled; the MRP plus 2 other physicians, Ontario Health atHome staff or regulated professionals; 10+ min about this resident. Max 4 per patient per 12 months. Today's visit is still paid if it wasn't during the conference (A31–A32, A38).	\$37.05

Did a procedure or test?

G310A + G313A	ECG done in your office, with your reading Needs symptoms, signs or a guideline indication; not routine pre-op for low-risk surgery (J14).	\$12.25
G313A	Reading an ECG done elsewhere Professional component only, written interpretation.	\$4.55
G650A	Holter reading, 12–35 h (Level 1) Professional component. 36–59 h G658A \$75.45; 60 h–13 days G659A \$95.85; 14+ days G649A \$122.25, once per 30 days (J16–J17).	\$47.90
G651A + G652A + G650A	Holter 12–35 h, your own device (Level 1) Recording + scanning + reading. 3+ channels, patient diary (J16).	\$113.65
G315A + G319A	Treadmill stress test in your office You must be in attendance throughout. Includes the resting ECGs (J15).	\$112.60
G319A	Treadmill stress test, supervising and reading only Hospital or other owner bills the technical part G315A.	\$62.05
J301B + J301C	Spirometry in your office Best of 3 efforts, written interpretation (H4).	\$18.70
J301B + J301C + J324B + J324C	Spirometry before and after bronchodilator	\$26.15
Z332A	Thoracentesis Diagnostic or therapeutic.	\$104.40
Z591A	Paracentesis with drainage With or without a sample.	\$57.65
Z590A	Diagnostic paracentesis (sample only)	\$31.30
G370A	Joint or bursa injection or aspiration Each extra joint G371A \$19.90.	\$20.25
G483A	Therapeutic phlebotomy (venisection) Blood removed as treatment, not for testing (J7).	\$9.70
G268A	Arterial line Cannulation for pressure measurement (J7).	\$31.25
G269A	Central venous line Pressure measurement or feeding line. Not with a right heart cath or Swan-Ganz (J7).	\$31.25
G328A	Complex joint or bursa aspiration	\$39.80
Z403A	Bone marrow aspiration or biopsy	\$133.55
Z804A	Lumbar puncture Includes image guidance if used (J83).	\$150.00
Z459A	Arterial puncture for blood gas	\$10.20
G517A	Ankle-brachial index	\$10.05
G271A	Warfarin dosing by phone, this month Long-term anticoagulant supervision, per month (J8).	\$13.10

Can I bill these together?

Code	With	Together ?	Why
G319A	A135A, A130A, A133A, A134A, A131A, A138A, C135A, C133A, C134A	Sometimes	The stress test reading includes the clinical assessment just before the test (J15). A visit is paid on top only when it's for something more than the pre-test check.
A135A	A133A, A134A, A131A, A138A, A435A, A136A	No	A consultation already includes the assessment; bill one or the other for the visit (GP16).
A130A	A135A, A133A, A134A, A131A, A138A	No	A130A replaces A135A when you spent 75+ minutes; it already includes the assessment (A129, GP16).
C130A	C135A, C133A, C134A, C131A	No	One consultation or assessment per visit; C130A replaces C135A when 75+ minutes (A130).
K013A	A135A, A130A, A133A, A134A, A131A, A138A, A435A, A136A	No	With counselling no consultation or assessment is paid the same day; only shots, blood draws, K002A/K015A and a few others (GP58).
K033A	A135A, A130A, A133A, A134A, A131A, A138A	No	With counselling no consultation or assessment is paid the same day (GP58).
K013A,K033A	K002A, K015A, G489A, G590A, G372A, K035A, K036A, K038A, K730A	Yes	These are on the list of services allowed with counselling (GP58).
K013A,K033A	K070A, K121A, K124A, K034A, K738A	No	With counselling, only the services listed in GP58 are paid the same day; this isn't one of them (GP58).
K002A	A135A, A133A, A134A, A131A, A138A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A,K739A	A135A, A130A, A133A, A134A, A131A, A138A, C135A, 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).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C138A	No	MRP premiums only go on visits by the MRP; concurrent care means the family doctor is MRP (GP47–48).
C122A,C123A,C142A,C143A	C124A, C126A	No	C122A/C123A/C142A/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).
C123A	C143A	No	Only one of C123A or C143A per admission (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C101A	G400A, G401A, G402A, G405A, G406A, G407A, G557A, G558A, G559A	No	C101A isn't paid with critical care, ventilatory or comprehensive care team (per diem) fees (GP103).
C101A	G521A, G523A, G522A	Yes	GP103 bars C101A only where critical care, ventilatory or comprehensive care team (per diem) fees are claimed; life-threatening critical care G521A–G523A is time-based, not a team fee (GP103, J30).
A120A	A133A, A134A, A131A, A138A	No	A120A is the only assessment paid on the colonoscopy day when a major pre-op visit was in the last 12 months (A129).
K001A	A135A, A133A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–30).
K001A	A130A	Sometimes	After a comprehensive consultation detention starts only past 120 minutes (GP31).
Z332A,Z591A,Z403A	A133A, A134A, A131A, A135A	Sometimes	Paid on top when you decide at this visit. If the procedure was planned at an earlier visit, only a partial assessment (A138A) is paid before it that day (SP4).
J301,J324	J304, J327	No	Spirometry isn't paid the same day as a flow-volume loop (H4).
G313A	G319A	No	The stress test fee includes the resting ECGs before and after (J15).

Code	With	Together ?	Why
G514A	G520A	No	One of G500A, G514A or G520A per patient per month; both in a month are paid as G520A (J42–J43).
G500A	G514A, G520A	No	One of G500A, G514A or G520A per patient per month (J42).
K045A,K046A	A135A, A130A, A435A, A136A, A133A, A134A, A131A, A138A	Yes	K045A and K046A are yearly management fees with no same-day rule; bill them on top of the visit (A99–A100).
G521A,G523A,G522A	G211A, G268A, G269A, Z459A, Z437A	No	Intubation, lines, arterial and central catheters, blood gases and cardioversion are included in life-threatening critical care (J26).
G521A,G523A,G522A	G395A	No	Other critical care G395A isn't paid with G521A, G522A or G523A the same day (J28).
G521A,G523A,G522A,G395A	G400A, G401A, G402A, G405A, G406A, G407A, G557A, G558A, G559A	No	Critical care time codes aren't paid the same day as a critical care, ventilatory or comprehensive care per diem (J27–J28).
G521A,G523A,G522A	A135A, A130A, A133A, A134A, C135A, C133A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and that time isn't counted (J26–J27).
G400A,G405A,G557A	C135A, C130A, C133A, C101A	No	The day-1 team fee includes the initial consultation and assessment, and C101A isn't paid with team fees (J31–J32, GP103).
G269A	Z438A	No	G269A isn't billed with a right heart catheterization or a Swan-Ganz insertion (J7).
K730A,K738A	A135A, A130A, A435A, A136A, A133A, A134A, A131A, A138A, C135A, C130A, C435A, C136A, C133A, C134A, C131A, C132A, C137A, C139A, C138A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	Your own phone consult or e-consult as the referring doctor is paid in addition to visits the same day. Not to arrange a referral, transfer, visit or test, or mainly to discuss results (A42, A48–A49).
K035A,K036A,K038A,K034A	A135A, A130A, A435A, A136A, A133A, A134A, A131A, A138A, C135A, C130A, C435A, C136A, C133A, C134A, C131A, C132A, C137A, C139A, C138A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A, W235A, W130A, W435A, W236A, W232A, W234A, W237A, W239A, W134A, W132A, W131A, W982A, W133A, W138A, W972A, W121A, W124A	Yes	These forms and reports have no same-day rule; paid on top of the visit (A59–A60).
K070A	A135A, A130A, A435A, A136A, A133A, A134A, A131A, A138A, C135A, C130A, C435A, C136A, C133A, C134A, C131A, C132A, C137A, C139A, C138A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	Paid in addition to the assessment, by the most responsible physician (A58).

Code	With	Together ?	Why
K121A	C135A, C130A, C435A, C136A, C133A, C134A, C131A, C132A, C137A, C139A, C138A, C122A, C123A, C124A, C126A, C142A, C143A, C121A, C982A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).
K124A	W235A, W130A, W435A, W236A, W232A, W234A, W237A, W239A, W134A, W132A, W131A, W982A, W133A, W138A, W972A, W121A, W124A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).
G373A	A135A, A133A, A134A, A131A, A138A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A per injection. Each extra injection after G373A is G372A (J54).

From the Ontario Schedule of Benefits (effective July 1, 2026): Internal Medicine listings A129–A131, General Preamble GP16–GP103, Diagnostic and Therapeutic Procedures (including Critical Care, J26–J32) and Pulmonary Function Studies. Totals leave out the age premium on specialist consultations for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance, and the 17% hospitalist premium that OHIP applies automatically to high-volume MRPs (GP103). Phone visits are shown at the 85% OHIP pays. Test fees with a technical part include it only where you own the equipment in your office; in hospital bill the reading (professional component) only. 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.