Medical Oncology OHIP Billing Cheat Sheet 2026

OHIP specialty 44 · New patient consultation · Clinic follow-up · IV chemotherapy or biologic · Updated November 2026
Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/medical-oncology

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

New patient consultation

A445A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same diagnosis: 1 per 2 years. Unrelated diagnosis: 1 per 12 months.	$183.40
A446A	Repeat consultation Same problem you consulted on before, another doctor cared for the patient in between, and a new written referral came in (GP19).	$115.95
A845A	Limited consultation A real referral, but a narrow question that took substantially less time than a full consult (GP19).	$115.95

- Recurrence after another doctor has treated the patient? Ask for a new written referral and bill the repeat consult A446A ($115.95) instead of a re-assessment A444A ($72.00) (GP19).
- Same patient, same diagnosis: 1 consultation per 2 consecutive 12-month periods. A 2nd in the first 12 months is paid as an assessment; a 2nd 12 to 24 months later is still a consult only for an in-patient or ED patient (GP17).
- No written, signed referral on file, or a referral from a medical trainee, means it is paid as an assessment (GP16–GP18).
- Started IV treatment the same day? The chemotherapy fee is paid on top of the consult (J3, J57).
- Patients under 16: OHIP adds 10% to 30% to specialist consultations on the remittance (GP64).

Clinic follow-up

A444A	Re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	$72.00
A441A	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 A443A).	$83.40
A443A	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
A448A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit (GP25).	$44.75

- Order to reach for: A441A ($83.40) when the case is complex and you write to the family doctor, then A444A ($72.00), then A448A ($44.75) (GP23–GP25).
- A444A is limited to 2 per patient per 12 months, and A443A + A441A together to 4. Past those OHIP pays a lesser fee, so a 3rd complex visit with a letter is better billed as A441A (GP23–GP24).
- E078A (+50%) only when the visit is for a GP26 chronic disease and you code it, e.g. 286 coagulation defect or 287 thrombocytopenia. The list has no cancer codes: never add it to a cancer visit (GP25–GP26).
- Starting a special oral agent (e.g. imatinib, capecitabine, lenalidomide)? Tick G388A ($28.00): it covers the lab review and all calls for 21 days, once a month (J59).
- Visiting the day after an infusion? Assessments by any physician in the 24 hours after treatment are included in the chemotherapy fee (J57).

IV chemotherapy or biologic

G345A	Complex therapy Agents that can cause vesicant damage, infusion reactions, or cardiac, neurologic, marrow or renal toxicity, e.g. rituximab, bevacizumab, trastuzumab, anthracyclines, bortezomib, taxanes, cisplatin, etoposide (J57).	$75.00
G381A	Standard therapy Minor-toxicity agents needing physician monitoring, e.g. cyclophosphamide, methotrexate, fluorouracil, leucovorin, zoledronic acid. Includes any added standard agent (J57).	$54.50
G359A	Special therapy Major toxicity, frequent monitoring and long administration, e.g. high-dose methotrexate with folinic acid rescue, cisplatin > 75 mg/m² with hydration, ifosfamide with MESNA, a biologic with complex chemotherapy, a bispecific antibody (J57).	$105.15
G390A	Induction, myeloablative, CAR-T or bispecific start Induction for acute leukaemia or myeloablative therapy before marrow transplant (1 per phase); a CAR-T infusion (1 per infusion); bispecific antibody initial dosing with high risk of cytokine release syndrome (max 3 per initial phase) (J58).	$262.40
G075A	Test dose of bleomycin or L-asparaginase Once per patient per drug (J58).	$30.50

- Match the regimen to the tier the Schedule's examples put it in: a bispecific antibody or a biologic with complex chemotherapy is G359A ($105.15), not G345A ($75.00) (J57).
- Assessed the patient at the treatment visit? The consult or assessment is paid on top (J3). Assessments by any physician in the next 24 hours are included (J57).
- Venipuncture, the IV line or port access and giving the drug are included: don't bill G489A or G379A (J55, J57).
- Biologics count only if they are monoclonal antibodies or cytokines. Blood products, insulin and vaccines don't (J57).
- G381A alone, outside hospital, with no visit billed? Add G700A ($8.80). Not for G345A or G359A, which aren't (+) procedures (J3, J57).

Oral chemo or phone supervision

G388A	Special oral chemotherapy started this month Agent with significant toxicity right after starting, e.g. fludarabine, imatinib, dasatinib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temozolomide, lenalidomide. Malignant disease only. You're available for 24 h after starting (J59). Limit: 1 per patient per month.	$28.00
G382A	Chemotherapy supervision by telephone, this month Monthly phone supervision of therapy for malignant or autoimmune disease (J58). Limit: Monthly.	$13.95

- G388A pays twice G382A and includes reviewing labs and imaging and every call about the drug for 21 days after it starts (J59).
- G388A isn't paid in a month where G382A is payable for the same patient: pick one (J59).
- A real assessment the same day is billed on top. Advice about the oral agent in the first 21 days is already part of G388A (J59).

Called to the ED

A445A	Consultation ED doctor's request on the chart; report back to them.	$183.40
A443A	Full assessment, no consult request e.g. your own patient sent in with febrile neutropenia.	$95.95
A444A	Re-assessment Your own patient you assessed recently.	$72.00
A448A	Quick look or advice	$44.75

- Not on ED duty and seeing a patient in the ED? Bill the A-code from the general listings plus the ED special visit premiums (K960A travel, K990A–K999A person seen) (A134, GP70).
- 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).
- Admitting the patient as MRP? This consult is the admission assessment: add E082A (+30%) (GP40, GP42).
- No E078A in the ED (GP25).
- Stayed with an unstable patient? Detention K001A ($21.10 per 15 min) starts after 60 minutes of a consult (GP29–GP31).

In-patient consult

C445A	Consultation Requested by the attending doctor; written report on the chart.	$183.40
C845A	Limited consultation Narrow question, substantially less time than a full consult (GP19).	$115.95
C446A	Repeat consultation Same problem after another doctor's care, new request (GP19).	$115.95
C443A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	$95.95
C444A	Re-assessment e.g. admitting a patient you assessed for the same illness.	$72.00
C441A	Complex re-assessment Complex, obscure or serious condition; findings in writing to the primary care physician (GP24).	$83.40
A445A	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 (A134, GP65).	$183.40

- Urgent call to the ward: bill A445A, not C445A, and add the in-patient special visit premiums for the time of day (A134, GP65–GP72).
- 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 own patient for the same illness and now admitting them: the admission assessment is a re-assessment (C444A, $72.00), not C443A (GP40).
- Seeing the patient in the ICU or CCU: add C101A ($9.10) per patient, unless critical care team fees are billed (GP103).

Hospital rounds

C122A	MRP visit, day after admission 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. Instead of C122A (GP46).	$71.80
C442A	Subsequent visit Weeks 1–5: C442A. Weeks 6–13: C447A, max 3 a week. After week 13: C449A, max 6 a month (A134).	$40.05
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
C448A	Concurrent care (family doctor stays MRP) 4 the first week, then 2 a week (GP48).	$40.05
C121A	Extra visit for an intercurrent illness Outside the weekly limits (GP43).	$40.05
C982A	Palliative care visit As MRP, for a patient receiving palliative care (GP50).	$40.05

- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays; medical oncology is on the E084A list. One per patient per day (GP47).
- C122A + E083A = $93.34 versus a plain C442A at $40.05: bill 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).
- Concurrent care C448A takes no E083A/E084A: you aren't the MRP (GP47–GP48).
- MRP for a palliative patient? The weekly case management fee G512A ($67.75) is paid in any location, on top of visits (J102).

Long-term care

W445A	Consultation in LTC or chronic care Written request from the attending doctor.	$183.40
W845A	Limited consultation	$115.95
W446A	Repeat consultation Same problem after another doctor's care, new request (GP19).	$115.95
W842A	Admission assessment, you're the attending Type 1: general assessment on admission. Saw them before admission (consult or general assessment)? Type 2 W844A $20.60. Re-admitted after 3+ days elsewhere: Type 3 W847A $30.70 (GP49).	$69.35
W849A	Periodic health visit The nursing home general re-assessment W444A ($20.60) only 6 months after it (A135).	$65.05
W442A	Chronic care hospital visit First 4 a month; then W441A, max 6 more. Palliative care visits: W982A (A135).	$40.05
W443A	Nursing home visit First 2 a month; then W448A, max 3 more. Palliative care visits: W972A (A135).	$40.05
W121A	Extra visit for an intercurrent illness Outside the monthly limits (GP49).	$40.05
A445A	Called in urgently (non-elective) A-prefix code with the LTC special visit premiums. Not for routine residents seen on the same trip (GP49, GP66).	$183.40

- 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: W982A in chronic care, W972A in a nursing home, $40.05 each (A135).
- Discharge after a 30+ day stay to another facility or home where a different provider takes over: W124A $71.80 (A20).
- No E078A in long-term care (GP25).

Counselling, family or palliative support

K013A	Counselling or education Booked visit only for advice and education. First 3 units per patient per 12 months (with K040A).	$80.00
K033A	Counselling, after the first 3 units this year	$56.30
K023A	Palliative care support Pain and symptom management, emotional support and counselling for a palliative patient. Start and stop times charted (A2).	$85.25
K002A	Interview with relatives or substitute decision-maker Separately booked, about the patient's care. Billed on the patient's number.	$80.00
K015A	Counselling relatives of a terminally ill patient Billed on the ill patient's number.	$80.00

- Counselling, interviews and palliative care support can be billed by any specialty (GP9). 20 minutes of K023A pays $85.25, more than A444A ($72.00).
- Units are by time: 20 min = 1 unit, 46 = 2, 76 = 3. Chart the start and stop times or it is paid at a lesser fee (A2, GP55).
- With counselling K013A/K033A, no consult or assessment is paid the same day. Shots, blood draws, K002A/K015A, the MTO report, the travel grant form and your own phone call for advice are allowed (GP58).
- Palliative patient's MRP? G512A ($67.75 a week) covers phone advice and arranging transfusions, drainage or rescue chemotherapy. In a G512A week no physician can bill G511A, K071A or K072A; K023A and visits still pay (J102).

Phone, video or advice to a doctor

A445A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	$183.40
A444A + K300A	Video re-assessment Full fee.	$72.00
A444A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	$72.00
A441A + K301A	Phone complex re-assessment, letter to family doctor 85% of $83.40.	$83.40
A448A + K301A	Phone quick follow-up 85% of $44.75.	$44.75
K731A	Phone call with the referring doctor or NP, 10+ minutes Patient-related discussion; chart start and stop times, reason and your advice (A42–A44). Limit: 1 per patient per day.	$47.75
K739A	E-consultation through a secure server Opinion sent within 30 days (A48).	$20.50

- Video pays 100%, phone 85%. A video re-assessment is worth $10.80 more than the same visit by phone (Appendix J, A70).
- Patient must have seen you in person in the last 24 months, or had a video consult with you (A66).
- Monthly phone supervision of chemotherapy is its own fee: G382A ($13.95), or G388A for a special oral agent (J58–J59).
- K731A and K739A need the referring doctor's or NP's billing number, and aren't paid if you see the patient the same or next day: bill the visit (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	Visit is for a GP26 chronic disease, not cancer +50%. Office or out-patient clinic. Only when the diagnosis coded on this claim is on the GP26 list (e.g. 286 coagulation defect, 287 thrombocytopenia, 282 hereditary haemolytic anaemia). Never with a cancer diagnosis code (GP25–GP26).	+50%
K708A	Discussed at a cancer conference (MCC) today Pre-scheduled MCC to Ontario Health standards; you took part. Per patient: total discussion 10 min × patients. Not if you're paid other than fee-for-service for it (A29–A30).	$37.05
K709A	Chaired the cancer conference (MCC) today Instead of K708A. Per patient, max 8 a day (A29).	$47.75
G388A	Started a special oral chemotherapy this month Malignant disease. Once per patient per month; not in a month G382A is payable (J59).	$28.00
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, C121A–C143A and C982A. 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 (40 for a re-assessment, 30 for A448A). Not for waiting (GP29–GP31).	$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	$80.00
G700A	Standard chemotherapy was the only reason for the visit With G381A only. Not in hospital, and not with a consult or assessment the same day (J3).	$8.80
A445A	Also saw the patient: consultation Consults and assessments are paid on top of chemotherapy fees (J3).	$183.40
A443A	Also assessed the patient: full assessment Paid on top (J3). Later assessments in the 24 h after treatment are included (J57).	$95.95
A444A	Also assessed the patient: re-assessment Paid on top (J3). Later assessments in the 24 h after treatment are included (J57).	$72.00
A441A	Also assessed the patient: complex re-assessment, letter to the family doctor Paid on top (J3). Written findings to the primary care physician (GP24).	$83.40
A448A	Also assessed the patient: quick look Paid on top (J3).	$44.75
A444A	Also saw the patient: re-assessment No same-day rule; bill it for an assessment, not only for advice about the drug (J58–J59).	$72.00

A441A	Also saw the patient: complex re-assessment, letter to the family doctor No same-day rule; bill it for an assessment, not only for advice about the drug (J58–J59).	$83.40
A448A	Also saw the patient: quick look No same-day rule; bill it for an assessment, not only for advice about the drug (J58–J59).	$44.75
G512A	Palliative care case management this week (MRP) Monday to Sunday, 1 per patient per week, MRP or substitute only. No G511A, K071A or K072A to any physician that week (J102).	$67.75
G489A	Blood draw Not on a chemotherapy day: included in G381A, G345A, G359A, G075A and G390A (J57).	$3.54
G372A	Injection with the visit (IM or SC) Each injection (J54).	$4.55
K035A	Reported a medical condition to the MTO (driving) 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
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 already get home care. Paid on top of the visit (A58–A59).	$34.75
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 (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 (A48).	$16.45
K121A	Hospital case conference, per unit Pre-scheduled; the MRP plus 2 other physicians or regulated professionals; 10+ min about this patient. Max 4 per patient per 12 months (A31–A33).	$37.05
K124A	Long-term care case conference, per unit Pre-scheduled; the MRP plus 2 others; 10+ min about this resident. Max 4 per patient per 12 months (A31–A32, A38).	$37.05

Did a procedure?

Z403A	Bone marrow aspiration or core biopsy Paid on top of the visit you decided it at (J3, J64, SP4).	$133.55
Z591A	Paracentesis with drainage With or without a sample (S34).	$57.65
Z591A + E724A	Paracentesis with chemotherapy or sclerosing agent instilled E724A adds $23.25 to the drainage (S34).	$80.90
Z590A	Diagnostic paracentesis (sample only) (S34).	$31.30
Z332A	Thoracentesis Diagnostic or therapeutic (P14).	$104.40
Z349A	Intrapleural chemotherapy or sclerosing agent By any method (P14).	$23.25
E542A	Tray fee: paracentesis or thoracentesis outside hospital Add to Z590A, Z591A or Z332A done in the office (P14, S34).	$12.65
Z804A	Lumbar puncture Includes any drug given at the time (e.g. intrathecal chemotherapy) and image guidance (J83).	$150.00
G483A	Therapeutic phlebotomy (venisection) Blood removed as treatment, not for testing (J7).	$9.70
G379A	IV injection Not into an established IV line, and not with chemotherapy codes, which include IV access (J55, J57).	$6.15
G373A	Injection was the only reason for the visit First IM or SC injection; each extra one G372A (J54).	$7.90
G389A	Gamma globulin infusion, per day Preparation and infusion (J55).	$13.90

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	A445A, A443A, A444A, A448A, C445A, C845A, C446A, C443A, C444A, C441A	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).
G381A,G345A,G359A,G390A,G075A	A445A, A845A, A446A, A443A, A444A, A441A, A448A, C445A, C443A, C444A, C441A	Sometimes	An assessment at the treatment visit is paid on top (J3), but assessments by any physician in the 24 hours after the treatment are included in the chemotherapy fee (J57).
G381A,G345A,G359A,G390A,G075A	G489A, G379A	No	Chemotherapy fees include venipuncture, setting up any vascular access line and giving the agent (J57).
G700A	A445A, A845A, A446A, A443A, A444A, A441A, A448A	No	G700A is for a visit where the + procedure was the only reason; not with a consult or assessment (J3).
G700A	G381A	Yes	G381A is a + procedure: add G700A once when it was the only reason for the visit, outside hospital (J3, J57).
G700A	G345A, G359A, G390A	No	G700A goes only with procedures marked +; G345A, G359A and G390A aren't (J3, J57–J58).
G388A	G382A	No	G388A isn't paid for the same patient in the same month as G382A (J59).
G382A	A445A, A443A, A444A, A441A, A448A	Yes	The monthly phone supervision fee has no same-day visit rule; a visit is billed on top (J58).
G388A	A445A, A443A, A444A, A441A, A448A	Sometimes	No same-day rule, but G388A already includes reviewing results and all discussion about the oral agent for 21 days after it starts; bill a visit for an assessment, not for that advice alone (J59).
Z591A	Z590A	No	Z590A is the diagnostic sample only; with drainage bill Z591A, which includes the sample (S34).
E724A	Z591A	Sometimes	E724A is an add-on to the paracentesis when you instil chemotherapy or a sclerosing agent (S34).
E542A	Z590A, Z591A, Z332A	Sometimes	E542A is added only when the paracentesis or thoracentesis is done outside hospital (P14, S34).
Z332A,Z591A,Z590A,Z403A,Z804A	A443A, A444A, A441A, A445A, C445A, C443A, C444A	Sometimes	Z-codes are independent procedures: paid on top of the visit you decide at, but if your major pre-procedure visit was in the last 12 months, only a partial assessment (A448A) is paid before it that day (J1, J3, SP4).
A445A	A443A, A444A, A441A, A448A, A845A, A446A	No	A consultation already includes the assessment; bill one consult or assessment for the visit (GP16).
C445A	C443A, C444A, C441A, C845A, C446A	No	One consultation or assessment per visit (GP16).

Code	With	Together?	Why
E078A	A445A, A845A, A446A, C445A, C443A, C444A, C441A, C442A, W445A, W842A, W442A, W443A	No	E078A goes only on office or out-patient medical specific assessments, re-assessments, complex re-assessments and partial assessments; not consultations, in-patients or LTC (GP25).
K013A	A445A, A443A, A444A, A441A, A448A, A845A, A446A	No	With counselling no consultation or assessment is paid the same day (GP58).
K033A	A445A, A443A, A444A, A441A, A448A	No	With counselling no consultation or assessment is paid the same day (GP58).
K013A,K033A	K002A, K015A, G489A, G372A, K035A, K036A, K730A	Yes	These are on the list of services allowed with counselling (GP58).
K002A	A445A, A443A, A444A, A441A, A448A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
G512A	K013A, K033A	No	With counselling no other service is paid the same day except a short list; G512A isn't on it (GP58).
K023A	K002A, K013A, K015A, K033A, K035A, K036A, K070A, K730A, K731A, K738A, K739A, K121A, K124A, K708A, K709A	No	Other Family Practice & Practice in General listings, such as these, aren't paid with palliative care support K023A (A2).
K708A,K709A	A445A, A446A, A845A, A443A, A444A, A441A, A448A, C445A, C443A, C444A, C441A, C442A, C122A, C123A, C124A	Yes	Only services given during the conference aren't paid; a visit outside it the same day is (A29).
K708A	K709A	No	Only one of K708A or K709A per physician per day (A29).
G512A	G511A, K071A, K072A	No	G511A, K071A and K072A aren't paid to any physician in a week G512A is billed (J102).
G512A	K023A, C982A, C442A, A444A, A441A, A448A, W972A, W982A	Yes	Assessments, subsequent visits, K023A and special visit premiums are still paid in a G512A week (J102).
G511A	A445A, A443A, A444A, A441A, A448A, K023A, K013A	No	G511A isn't paid the same day as a consultation, assessment, time-based service or other visit by the same physician (J101).
K731A,K739A	A445A, A443A, A444A, A441A, A448A, C445A, 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	A445A, A443A, A444A, A441A, A448A, C445A, C443A, C444A, C441A, C442A	Yes	Your own phone or e-consult as the referring doctor is paid in addition to the visit (A42, A48).
K035A,K036A,K070A	A445A, A845A, A446A, A443A, A444A, A441A, A448A, C445A, C443A, C444A, C441A, C442A	Yes	These forms and reports are paid on top of the visit (A58–A60).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C448A	No	MRP premiums only go on visits by the MRP; concurrent care means the family doctor is MRP (GP47–GP48).
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 (GP46).

Code	With	Together?	Why
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
K001A	A445A, A443A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–GP30).
G373A	A445A, A443A, A444A, A441A, A448A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A per injection (J54).
K124A	W445A, W845A, W446A, W842A, W849A, W442A, W443A, W121A	Yes	A visit the same day is paid; only services given during the case conference aren't (A32).

From the Ontario Schedule of Benefits (effective July 1, 2026): Medical Oncology listings A134–A135, cancer conferences A29, Chemotherapy J57–J59, Palliative Care J101–J102, General Preamble GP16–GP103 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. G700A is shown at its full fee; it pays 15% for patients enrolled in a capitation group (J3). 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.