

Neurology OHIP Billing Cheat Sheet 2026

OHIP specialty 18 · Stroke code (ACVS) · Read an EEG · EMG / nerve conduction · Updated October 2026

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

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

Office consultation

A185A	Consultation Written referral from a physician or NP; written report back.	\$225.55
A180A	Special consultation, 75+ min face to face All consult elements plus 75 minutes of direct contact. Start and stop times in the chart.	\$342.25
A682A	Extended special consultation, 90+ min All consult elements plus 90 minutes of direct contact. Start and stop times in the chart.	\$442.40
A186A	Repeat consultation Same problem, after another physician cared for the patient in between; new written referral.	\$125.50
A385A	Limited consultation Consult that needed much less time than a full one.	\$125.50

- 75 minutes face to face turns A185A (\$225.55) into A180A (\$342.25); 90 minutes makes it A682A (\$442.40). Time excludes procedures you bill separately and chart, imaging or note time (A140).
- No start and stop times in the chart: A180A/A682A are not paid at that level (A140).
- Without a written referral, or without a written report back, it is paid as an assessment (GP16). Same diagnosis: 1 consult per 2 years; a clearly unrelated one, 1 per 12 months (GP17).
- Under 16: OHIP adds 10–30% to consults on the remittance (GP64).
- Did formal cognitive testing (memory, attention, language, visuospatial, executive) on top of the consult? K042A (\$140.20) for 46+ min, K032A (\$80.00) for 20+ min; that time doesn't count toward A180A/A682A (A58, A140).

Office follow-up

A184A	Re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months.	\$64.95
A181A	Complex re-assessment, report to family doctor Complex, obscure or serious condition. Written findings to the primary care physician. Limit: 4 per 12 months.	\$75.20
A113A	Complex neurological assessment, 20+ min Ongoing care of neuropathy, myopathy, NMJ disease, motor neurone disease, brain tumour or CNS metastasis, FND, chronic migraine or TAC, Huntington's, trigeminal neuralgia, ICH, stroke, or neuro-oncology complications. Start and stop times. Limit: 6 per 12 months.	\$120.00
A183A	Full specific assessment Full history of the complaint and detailed exam of the affected systems. Limit: 1 per 12 months (2 if a new diagnosis).	\$82.40
A188A	Partial assessment History of the complaint, needed exam, advice.	\$39.40

- Patient with one of the A113A conditions and 20+ minutes face to face? A113A pays \$120.00, almost double A184A (\$64.95). Not for your first evaluation of the patient; established diagnosis in the chart (A141–A142).
- Epilepsy, MS, Parkinson's, cerebral palsy or dementia (not on the A113A list)? Add E078A: +50% in the office or hospital clinic. A181A + E078A pays \$112.80, A184A + E078A \$97.43. Diagnostic code 345, 340, 332, 343 or 290, or any other on the GP26 list, e.g. 250 for diabetes with complications (GP25–26).
- E078A can't be added to A113A (A142).
- A181A needs a written report to the family doctor. A183A and A181A together are capped at 4 per 12 months; A184A at 2 (GP23–24).

Stroke code (ACVS)

A384A	In the ED Referred for suspected acute stroke within the thrombolysis window.	\$275.95
C384A	In-patient Same conditions as A384A.	\$275.95

- A384A is the full consult plus thrombolysis and monitoring, in a hospital with CT or MRI on site, neurologist only, in constant attendance (A142–A143).
- Gave IV thrombolysis? Add K181A (\$90.00) per 30 minutes after the first 30, max 6 per day (A143).
- Chart start and stop times and the time of symptom onset, or nothing is paid (A142).
- Critical care codes G521A, G522A, G523A and G391A can't be billed with A384A or K181A (A143).

Read an EEG

G418A	Routine EEG, 16–21 channels Professional fee (interpretation).	\$62.50
G415A	Routine EEG, under 16 channels 20+ min recording, 8+ channels. Professional fee.	\$23.15
G543A	Sleep-deprived or sedated EEG 60+ min, 16+ channels, 2+ physiological parameters. Professional fee.	\$120.00
G496A	EEG with time-locked video 30+ min, 16+ channels, 2+ physiological parameters. Professional fee.	\$120.00
G555A	Ambulatory EEG, 12–24 h Professional fee.	\$120.00
G545A	Prolonged video-EEG monitoring, first 15 min Per 15 min unit; add more units below. Professional fee.	\$14.70

- A routine EEG with 16–21 channels pays \$62.50 as G418A, not \$23.15 as G415A (J84).
- Only one of G415A, G418A, G543A or G496A per day. A sleep-deprived or video EEG that misses the time, channel or parameter minimums is paid as a routine EEG (J84).
- G545A is max 18 units per day and 14 services per admission, pays nil with a baseline EEG, and not for routine sedation or anaesthesia monitoring (J85).
- No EEG is paid with any sleep study the same day (J84).

EMG / nerve conduction

G456A	Complete study (Schedule A), interpretation only 2+ nerves plus EMG of appropriate muscles; hospital or someone else's lab.	\$120.00
G455A + G456A	Complete study, your own equipment You own the equipment and do it or supervise your technician.	\$151.80
G457A	Limited study (Schedule B), interpretation only Single nerve and/or limited EMG.	\$74.40
G466A + G457A	Limited study, your own equipment	\$95.80
G473A	Complex study (Schedule C), 60+ min, interpretation 10+ studies (NCS, late responses, needle EMG, repetitive stimulation, autonomic). Start and stop times.	\$275.00
G471A + G473A	Complex study, your own equipment	\$306.80

- Patient referred straight to your lab for the test? No consult or assessment is paid unless the referrer also asked for one (J103).
- Own the machine and do or supervise the study? Bill technical + professional (J103).
- Schedule C (G473A, \$275.00) needs 60+ minutes of your own time and 10+ studies; not with G456A/G457A the same day (J104).
- Needle EMG only: surface EMG is not paid (J103).

Botulinum toxin

G875A	Cervical, limb or oromandibular dystonia, or spasticity First injection; add more below.	\$40.00
G871A	Blepharospasm Unilateral or bilateral.	\$120.00
G872A	Hemifacial spasm Unilateral or bilateral.	\$120.00
G873A	Spasmodic dysphonia	\$120.00
G874A	Sialorrhea or epiphora Unilateral or bilateral.	\$120.00

- Each extra injection site for dystonia or spasticity adds G876A (\$10.00), up to 11: 12 sites pay \$150.00 (J51).
- Botox for other indications, chronic migraine included, is not an insured service; don't bill these codes for it (J52).
- One treatment per condition every 10 weeks; more often needs manual review with documentation (J52).
- EMG or ultrasound to find the site: only G877A/G878A are paid, not EMG codes. E543A adds \$30.60 for a disposable EMG needle outside hospital (J51–J52).
- Phenol or alcohol into the same muscle the same day pays nil (J105).

ED consult

A185A	Consultation Written request from the ED physician.	\$225.55
A180A	Special consultation, 75+ min Start and stop times.	\$342.25
A186A	Repeat consultation	\$125.50
A385A	Limited consultation	\$125.50
A183A	Specific assessment No referral, or your own patient.	\$82.40

- Not on ED duty, seeing a patient in the ED or out-patient department: bill the A codes (A144).
- Called in from outside the hospital, or after hours? Set it in the header: the special visit premiums are added for you. Chart the time (GP65, GP69).
- Suspected stroke in the thrombolysis window? Use the Stroke code tile: A384A pays \$275.95 (A142).
- Admitting as MRP: this consult is the admission assessment; add E082A (+30%), once per admission (GP40, GP42).

In-patient consult

C185A	Consultation, routine Requested consult seen as part of your hospital day.	\$225.55
A185A	Consultation, called in urgently Non-elective call to the ward; in-patient premiums apply.	\$225.55
C180A	Special consultation, 75+ min Start and stop times.	\$342.25
C183A	Specific assessment Admission assessment of your own patient.	\$82.40
C113A	Complex neurological assessment Same conditions as A113A.	\$120.00
C181A	Complex re-assessment Report in writing to the primary care physician.	\$75.20

- Urgent call to an in-patient (not on rounds)? Use the A185A option: same fee plus the in-patient special visit premiums (A144, GP72).
- Admitting as MRP: E082A adds 30% to the admission assessment, once per admission (GP42).
- One consult or admission assessment per admission, even if the patient moves between physicians (GP40).

Hospital rounds

C182A	Subsequent visit, weeks 1–5	\$40.05
C122A	MRP visit, day after admission 1 per admission.	\$71.80
C123A	MRP visit, second day after admission 1 per admission.	\$71.80
C124A	MRP visit, discharge day Stay 48 h+; discharge summary within 48 h and follow-up arranged.	\$71.80
C126A	MRP discharge, complex patient Stay 7+ days, 3+ diagnoses, 45+ min.	\$95.10
C187A	Subsequent visit, weeks 6–13 Limit: 3 per week.	\$40.05
C142A	MRP, 1st visit after transfer out of ICU Patient was getting critical, ventilatory or comprehensive care there, not just monitoring. Instead of C122A; not if you gave the critical care (GP46).	\$71.80
C143A	MRP, 2nd visit after transfer out of ICU Instead of C123A; same conditions as C142A (GP46).	\$71.80

- As MRP, C122A/C123A the two days after admission and C124A on discharge day pay \$71.80 instead of \$40.05 (GP44–45).
- MRP on a subsequent visit: add E083A (+30%), or E084A (+45%) on a Saturday, Sunday or holiday. One per patient per day; not if the hospital pays you for in-patient work without reducing it (GP47).
- Patient came to you from the ICU? C142A/C143A pay \$71.80 instead of \$40.05 for your first two visits; one of C122A/C142A and one of C123A/C143A per admission (GP46).

- After week 13: C189A, max 6 per month. Acute intercurrent illness after week 5: C121A, outside those limits (GP43). Concurrent care while another physician stays MRP: C188A. Palliative care as MRP: C982A (GP50, A144).

Phone or video

A184A + K300A	Video follow-up, known patient Seen in person in the last 24 months, or in a video consult relationship. Full fee.	\$64.95
A184A + K301A	Phone follow-up, known patient Phone pays 85% of the in-person fee.	\$64.95
A113A + K301A	Phone complex neurological assessment 85% of A113A; same conditions, 20+ min.	\$120.00
A185A + K300A	Consultation by video Consults are video only, never phone.	\$225.55
A101A	Video, new to you, no relationship Limited virtual care.	\$20.00
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit or transfer, or mainly about results. Not paid if you see the patient that day or the next (A42–A43).	\$47.75
K733A	CritiCall phone consult Arranged by CritiCall Ontario, e.g. a stroke or seizure call from another hospital (A45–A46).	\$47.75
K739A	e-Consult reply Opinion through a secure server within 30 days. Max 1 a day and 6 per patient per 12 months. Not paid if you see the patient that day or the next (A48–A49).	\$20.50

- The patient (or the referral) has to start the contact; a check-in call you start isn't billable (A68).
- Consults, A180A/A682A and in-patient C codes are video only. A follow-up by phone pays 85% (A70, Appendix J).
- E078A can be added to virtual follow-ups too (A74).
- CritiCall call where you reviewed the CT, MRI or angiogram the referring doctor sent? Add E150A (\$44.00) to K733A, analysis charted; not if you see the patient yourself that day or the next (A45–A46).

Also bill, if it's true

E078A	Epilepsy, MS, Parkinson's, CP or dementia +50%. Office or hospital clinic, not ED or in-patient. Established chronic disease with a dx on the GP26 list: 345, 340, 332, 343, 290, 250 diabetes with complications, and others (GP25–26).	+50%
E078A	Epilepsy, MS, Parkinson's, CP or dementia +50% (GP25, A74).	+50%
K181A	Gave IV thrombolysis: each 30 min after the first 30 Constant attendance; max 6 per day (A143).	\$90.00
G545A	Each more 15 min of monitoring Max 18 units per day (J85).	\$14.70
G546A	Radiotelemetry or portable recording Added to the routine EEG fee (J85).	\$30.45
G458A	Single fibre EMG With G473A only when its time isn't counted in G473A's 60 minutes (J104–J105).	\$275.00
G876A	Each more injection site Max 11 (J51).	\$10.00
G877A	EMG or ultrasound guidance, one injection	\$18.85
G878A	EMG or ultrasound guidance, 2+ injections With G875A only when G876A is also billed (J51).	\$28.10
E543A	Disposable EMG needle, outside hospital With G877A or G878A; max 1 per day (J51).	\$30.60
E082A	You admitted the patient as MRP +30% on the admission assessment, once per admission (GP42).	+30%
E083A	You are the MRP, weekday +30% (GP47).	+30%
E084A	You are the MRP, Saturday, Sunday or holiday +45% (GP47).	+45%
K042A	Extended cognitive testing, 46+ min Memory, attention, language, visuospatial and executive tests, done personally, time dedicated to the testing (e.g. TorCA, BNA-SF + MoCA). Start and stop times. One of K032A or K042A a day (A58).	\$140.20
K032A	Cognitive testing, 20+ min Same five domains, done personally, 20+ minutes dedicated to it. MMSE alone doesn't count. Start and stop times (A58).	\$80.00
K035A	Reported a driving concern to the MTO Mandatory medical report (e.g. seizure, dementia); includes any follow-up information on the same report. More than 1 a year: manual review with notes (A59).	\$36.25
K036A	Filled in the Northern Health Travel Grant form Specialist's part of the form; payable to the referring doctor and the specialist (A60).	\$10.25
K002A	Separately booked interview with relatives or substitute decision-maker Per unit: 20 min = 1, 46 = 2, 76 = 3. Its own booked appointment, when the information can't come from the patient (e.g. dementia, ALS); not the visit's history-taking, not only for consent (A28, GP61).	\$80.00
K070A	Home care referral form to Ontario Health atHome You're the MRP giving ongoing care. Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K070A	Home care referral form at discharge You're the MRP and will keep caring for the patient. Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K730A	Phoned another specialist for advice about this patient You're the referring doctor and keep the patient's care; 10+ minutes, start and stop times charted. Not to arrange a referral, a transfer or to discuss test results. Paid on top of today's visit; 1 per patient per day (A42–A44).	\$37.05

K121A	In-patient case conference Per 10-minute unit (10, 16, 26, 36 min...). Pre-scheduled, with the MRP plus 2+ other physicians or regulated professionals; chart start/stop, participants and outcome. Paid with today's visit if the visit was done outside the conference. Max 4 per patient per 12 months, 8 units a day (A31–A33).	\$37.05
E150A	Reviewed the complex neuroimaging sent with the call At least one brain or spine CT, MRI or angiogram; your analysis in the chart. Max 1 a day; not if you see the patient that day or the next (A45–A46).	\$44.00
A184A	Also re-assessed the patient Injections are paid on top of an assessment (J3). Preparing the patient and advice about the injection are already in the injection fee (J3), so chart the re-assessment's own history and exam.	\$64.95
A188A	Also did a partial assessment Paid on top of the injection (J3). Chart a history and exam beyond preparing the patient for the injection, which the injection fee covers (J3).	\$39.40

Did a procedure?

Z804A	Lumbar puncture Includes medication given and image guidance (J83).	\$150.00
G264A	Occipital nerve block 1 per day, max 16 first blocks per calendar year (J80).	\$34.10
G265A	Each more occipital block, per level Max 3 per day, only with G264A (J80).	\$17.10
G291A	Occipital nerve block, past 16 first blocks this year Independent consideration: needs a written recommendation from an independent pain expert, each 16 blocks (J80).	\$19.85
G292A	Each more occipital block after G291A, per level Max 3 per day, only with G291A (J80).	\$10.00
G235A	Supraorbital nerve block	\$34.10
G227A	Other cranial nerve block Max 8 blocks per patient per day in total (J79).	\$54.65
G138A	Evoked potentials, upper or lower limbs, interpretation One limb only: 50% (J86).	\$71.65
G485A	Phenol or alcohol nerve injection for spasticity First major nerve (J105).	\$45.45
G486A	Each more nerve, same day With G485A (J105).	\$28.50
G487A	Phenol or alcohol injection, repeat within 30 days First major nerve, within 30 days of the last chemodenervation (J105).	\$28.50
G488A	Each more nerve on a repeat, same day With G487A (J105).	\$18.80
G384A	Trigger point injection First site (J54).	\$8.85
G385A	Each more trigger point site Max 2, with G384A (J54).	\$4.55
G921A	Spheno-palatine ganglion block, transnasal topical Uni or bilateral; not with G232A the same day (J78).	\$12.50
G547A	Deep brain stimulator programming, first site Max 1 per patient (J83).	\$185.70
K180A	Parkinson's infusion pump titration, per 30 min Max 4 units a day, 20 a year; no other assessment that day (A140–A141).	\$125.00
G372A	Injection with the visit (e.g. B12) Each intramuscular or subcutaneous injection; paid on top of the assessment (J3, J54).	\$4.55

Can I bill these together?

Code	With	Together ?	Why
G547A	A184A, A188A, A183A, A181A	Sometimes	G547A includes the visits for checking the stimulator (J83). An assessment is paid on top only when it's for a different problem.
A113A	E078A	No	E078A is not payable with A113A (A142).
E078A	A185A, A180A, A682A, A385A, A186A, C183A, C184A, C181A	No	E078A adds only to office or clinic A183A, A184A, A181A or A188A, not consults or in-patient visits (GP25).
A384A,C384A,K181A	G521A, G522A, G523A, G391A	No	Critical care codes are not payable with A384A or K181A (A143).
K180A	A183A, A184A, A181A, A188A, A113A, A185A, A186A, A385A, A180A, A682A, A384A, C384A, C185A, C183A, C182A	No	K180A includes any assessment; no other assessment by you that day (A141).
G414A	G541A	No	G414A is not payable with G541A (J84).
G415A,G418A,G543A,G496A	G415A, G418A, G543A, G496A	No	Only one of G415A, G418A, G543A or G496A per day (J84).
G545A	G415A, G418A, G543A, G496A, G555A	No	G545A pays nil with a baseline EEG or any other professional EEG that day (J85).
G473A	G456A, G457A	No	G473A is not payable with G456A or G457A the same day (J104).
G471A	G455A, G466A	No	G471A is not payable with G455A or G466A the same day (J104).
G456A,G457A,G473A	A185A, A183A, A184A	Sometimes	Referred directly for EMG/NCS: no consult or assessment unless the referrer also asked for one (J103).
G877A,G878A	G456A, G457A, G473A	No	With botulinum toxin, only G877A/G878A are paid for EMG or ultrasound guidance (J52).
G876A	G871A, G872A, G873A, G874A	No	G876A adds only to G875A (J51).
G485A,G486A	G875A, G876A	Sometimes	Chemodenervation into the same muscle as botulinum toxin the same day pays nil; different muscles are fine (J105).
G264A	G291A	No	G291A pays nil when G264A is paid the same day (J80).
G265A	G292A	No	G292A pays nil when G265A is paid the same day (J80).
G292A	G264A	No	G292A is paid only with G291A; after G264A bill G265A (J80).
G488A	G485A	No	G488A adds to the repeat injection G487A; with G485A the extra nerve is G486A (J105).
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP46).
Z804A	A185A, A183A, A184A, A181A, A113A	Yes	Procedures are paid on top of the consult or assessment (J3).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
K032A	K042A	No	Only one of K032A or K042A per physician per day (A58).

Code	With	Together ?	Why
A185A,A180A,A682A,A186A,A385A,A183A,A184A,A181A,A188A,A113A,C185A,C183A	G418A, G415A, G543A, G496A, G555A, G545A	Yes	Diagnostic and therapeutic procedures, EEG reading included, are paid on top of a consultation or assessment (J3).
A183A,A184A,A181A,A188A,A113A	G875A, G871A, G872A, G873A, G874A	Yes	Injections are paid on top of an assessment (J3). Preparing the patient and advice about the injection are part of the injection fee, so chart the assessment's own history and exam (J3).
K731A,K739A	A185A, A180A, A682A, A186A, A385A, A183A, A184A, A181A, A188A, A113A, A384A, C384A, C185A, C183A, C182A, K180A	No	Your phone advice (K731A) or e-consult reply (K739A) isn't paid if you see the patient yourself (consult, assessment, visit or K time code) the same day or the next (A43, A49).
E150A	A185A, A180A, A682A, A186A, A385A, A183A, A184A, A181A, A188A, A113A, A384A, C384A, C185A, C180A, C183A, C182A, K181A	No	E150A isn't paid when you see the patient yourself (consult, assessment, visit or K time code) the same day or the next (A46).
K733A	A384A, C384A, A185A, C185A	Yes	No same-day or next-day restriction on K733A itself; only the E150A imaging add-on is lost if you then see the patient (A45–A46).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (A140–A145, A28, A31–A33, A42–A49, A58–A60, GP16–GP26, GP61, GP40–GP47, GP64–GP72, J3, J51–J52, J54, J79–J86, J103–J105). EEG, EMG and evoked potential fees shown are the professional (interpretation) component unless the option says you own the equipment; technical components are in the lookup. The total leaves out the under-16 age premiums OHIP adds to consults and procedures (GP64).

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