Neurosurgery OHIP Billing Cheat Sheet 2026

OHIP specialty 04 · Called to ED or ward · Brain tumour or vascular (booked) · Head injury, bleed or hydrocephalus · Updated November 2026

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

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

Office consultation

A045A	Consultation Written referral from a physician or NP; written report back. Limit: 1 per patient per 2 years for the same diagnosis (GP17).	$145.60
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or reviewing imaging. Chart start and stop times (GP7, GP19–GP20).	$194.65
A046A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	$64.85

- 50+ minutes face to face? A935A pays $194.65, $49.05 more than A045A. Time reviewing imaging or doing procedures doesn't count (GP19–GP20).
- This is usually your decision-to-operate visit: it's paid on top of the surgery whenever the surgery happens (SP2).
- A second consult for the same diagnosis within 2 years is paid as a specific assessment, unless it's a repeat consult or an in-patient/ED consult 12–24 months later (GP17).
- Ask for the written request before you see the patient; one asked for afterwards makes it an assessment, not a consult (GP16).
- Brain or spine tumour case at a scheduled cancer conference? K708A ($37.05) is paid the same day as the visit (A29).

Office follow-up

A044A	Follow-up or post-op visit History of the problem, the exam needed, advice. Partial assessment.	$33.40
A043A	Full work-up of one problem Full history of the complaint and detailed neurological exam of the affected part. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	$64.90

- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- A043A pays $64.90, almost double A044A, but only once a year per patient (twice for a clearly different diagnosis) (GP23).
- Planned Z-code procedure today (e.g. lumbar puncture, shunt tap, pump programming) decided at an earlier visit? A044A is the only visit payable before it (SP4 §13).
- Phoned or e-consulted another physician about this patient? K730A ($37.05) or K738A ($16.45) is paid on top of today's visit. Gave the advice yourself? K731A ($47.75) or K739A ($20.50), but not if you see the patient that day or the next (A42–A49).
- E078A (chronic disease premium) isn't payable to neurosurgery (04): GP25 limits it to 13 other specialties.

Called to ED or ward

A045A	Consultation Requested by the ED or ward physician. Written report.	$145.60
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	$194.65
A046A	Repeat consultation Same problem, new request, after another physician's care in between.	$64.85
A043A	Full work-up, your own patient Specific assessment.	$64.90
A044A	Brief assessment Partial assessment.	$33.40

- Seeing patients in the ED or out-patient department, or called to an in-patient, when you're not on ED duty: use these A-codes plus the special visit premiums, not C-codes (A146, GP65).
- The premiums shown are the ED table (I). For an in-patient on a ward (table III) or an out-patient clinic (table II) bill that table's codes (GP71–GP72).
- EVD or ICP monitor at the bedside: Z820A ($395.85) is paid on top of the consult, 1 per patient per day. After hours, tick E409A or E410A for the procedure (X5, GP104).
- Head injury managed without surgery is billed as visits (X6). Critically ill with an acute brain injury and you're most responsible? See the brain injury tile (J87).
- Admitting the patient as MRP? E082A adds 30% to this consult, once per admission (GP42).

Brain tumour or vascular (booked)

N103A	Craniotomy, glioma or metastasis, supratentorial Astrocytoma, oligodendroglioma, glioblastoma, metastasis. Infratentorial: N151A ($2,004.00) (X1).	$1,877.70
N102A	Craniotomy, meningioma or other tumour, supratentorial Includes pituitary tumours by craniotomy (X1).	$2,004.00
N153A	Craniotomy, meningioma or other tumour, infratentorial or skull base With N200A or R380A: manual review with documents (X1).	$2,817.30
N151A	Craniotomy, glioma or metastasis, infratentorial X1.	$2,004.00
N114A	Endoscopic transsphenoidal pituitary resection Lesion in the sella, simple closure. Microscopic: N111A ($2,021.40) (X10).	$1,742.45
N116A	Endoscopic endonasal resection, non-pituitary lesion e.g. craniopharyngioma, chordoma, meningioma (X10–X11).	$2,243.45
N105A	Aneurysm clipping, carotid circulation, per vessel Vertebrobasilar: N154A ($2,759.00) (X1).	$2,665.20
N129A	Chiari decompression (posterior fossa) X4.	$1,577.05

- Operating microscope: E901A adds $252.40, but only to the codes it's listed under: tumour, aneurysm, AVM, Chiari, N266A/N267A and orbital craniotomies (X1–X9).
- Meningioma or other tumour over 2 cm: E902A adds $454.15 to N102A or N153A (X1).
- Did the endonasal approach yourself as well as the resection? E905A adds $750.00 to N111A, N114A or N116A. A surgeon who only does the access bills N112A (X10).
- No respiratory or skin-section codes (septoplasty, sphenoidotomy, flaps) are paid with N111A, N112A, N114A or N116A; complex closure E893A needs a lesion beyond the sella, a CSF leak repair and a pedicled flap over 3 cm (X10–X11).
- Redo surgery: E921A adds $262.15 to any open intracranial procedure and to N111A, N114A and N116A, not N127A. Duroplasty over 2 cm: E919A ($254.45) (X1).

Head injury, bleed or hydrocephalus

N144A	Craniotomy for subdural or extradural haematoma Extracerebral haematoma or hygroma (X6).	$999.30
N143A	Burr hole drainage of haematoma, one side Not with N144A or N148A for the same craniotomy (X6).	$647.80
N148A	Intracerebral haematoma removal or debridement of brain Includes management of any skull fracture (X6).	$1,341.55
N104A	Spontaneous intracerebral haemorrhage, supratentorial Infratentorial: N157A ($1,704.00). Burr hole drainage: N120A ($481.90) (X3).	$1,416.40
N200A	Decompressive craniectomy Frontal or sub-temporal (X6).	$1,018.45
N140A	Compound skull fracture Simple depressed: N139A ($634.90). Dural repair: add E912A (X6).	$1,098.45
N230A	CSF shunt, any type Operative revision: N245A ($674.70). Third ventriculostomy: N249A ($1,084.25) (X8).	$1,105.25
N127A	Re-opening of craniotomy Post-op haematoma or bone flap removal. E921A isn't added to it (X1, X4).	$518.85

- Bill the ED consult with its travel and first-person premiums from the Called to ED tile; it's paid with the operation (SP2 §2).
- Started 17:00–24:00 weekdays or any time on a weekend or holiday: E409A +50%; 00:00–07:00: E410A +75% (GP104).
- Trauma with ISS over 15 (over 12 under 16): E420A adds 50% to the consult and the operation within 24 hours, ISS in the chart (GP109).
- Two operations on the same day for the same condition under one anaesthetic: the second is paid at 85% (SP2 §3). A new complication needing a return to the OR is paid in full (SP2 §4).
- After an intracranial operation by a neurosurgeon (other than EVD, burr hole aspiration of an abscess, a simple depressed fracture and the other J87 exceptions), no one can bill brain injury management for that admission (J87).

Spine surgery (booked)

N511A	Lumbar decompression, one level, one side Hemi or total laminectomy, foraminotomy, facetectomy. Discectomy: add E368A (Z6).	$800.70
N512A	Lumbar decompression, one level, both sides Z6.	$1,118.90
N524A	Lumbar bilateral canal enlargement, one-sided approach One level (Z6).	$1,300.25
N509A	Cervical or thoracic posterior decompression, one side Z6.	$1,004.70
N510A	Cervical or thoracic posterior decompression, both sides Foramen magnum under 3 cm: add E374A (Z6).	$1,346.05
N520A	Laminoplasty, one level Includes fixation of lamina. Each more level: E380A (Z6).	$1,514.70
N500A	Anterior cervical discectomy, one level Corpectomy: N501A ($1,267.15). Fusion: add E365A (Z3–Z4).	$1,097.90
N560A	Intradural extramedullary tumour removal Intramedullary: N561A ($2,927.70). No other decompression codes with them (Z11).	$2,536.80

- Lumbar microdiscectomy: N511A + E368A = $1,106.70; both sides N512A + E368A = $1,424.90. Each more level decompressed, with or without disc: E361A ($260.80) (Z6).
- The operating microscope is part of every spinal code: never bill E901A or anything else for it (Z2).
- Interbody fusion (TLIF/PLIF) E372A ($510.00) includes the discectomy, so no E368A for that disc. Morselized graft alone isn't E372A (Z8).
- Instrumented posterior fusion E370A pays $880.15, uninstrumented E369A $255.00. One fusion level includes two levels of instrumentation, and bone graft harvest is included (Z1, Z7).
- Redo surgery: E373A adds 30% to the main decompression; E375A adds 30% to the main fusion code (Z13). Navigation E378A/E379A ($510.00) needs a tracked navigation system; fluoroscopy alone isn't paid (Z1).

Spine fracture or cord compression

N572A	Open reduction of spine fracture/dislocation, one level Anterior or posterior. Includes decompression at that level; fusion paid on top (Z10).	$1,097.30
N510A	Cervical or thoracic decompression, both sides Cord compression, e.g. tumour, abscess or injury (Z6).	$1,346.05
N512A	Lumbar decompression, both sides e.g. cauda equina (Z6).	$1,118.90
N573A	Anterior odontoid screw Nothing else from the spinal section except navigation (Z10).	$1,020.00
F201A	Closed reduction in halo or tong traction Z10.	$280.50
F200A	Fracture, no reduction, brace or halo Total care by the operating surgeon (Z10).	$178.50
N583A	Kyphoplasty, first level, sole procedure Each more level: E393A. Vertebroplasty: N570A ($1,004.50) (Z10).	$1,201.55

- Acute spinal cord injury, ASIA A–C, present 6 weeks or less: E383A adds $255.00 (Z1).
- Extradural cord or cauda equina decompression for tumour or infection: E386A adds 42% to the main decompression (Z11).
- Fracture open reduction includes the decompression at that level, but a fusion is paid on top: E370A or E365A plus E366A per extra level (Z10).
- Kyphoplasty takes only E393A, vertebroplasty only E391A, odontoid screw only navigation; no other spinal codes with them (Z10).
- Non-elective case started 17:00–24:00 weekdays or any time on a weekend/holiday: E409A +50%; 00:00–07:00: E410A +75%. Bill the ED consult and premiums too (SP2 §2, GP104).

Peripheral nerve surgery

N290A	Carpal tunnel release X12.	$197.15
N190A	Ulnar nerve decompression at the elbow Exploration, decompression and/or neurolysis (X12).	$286.20
N189A	Ulnar nerve transposition at the elbow May include exploration, decompression and neurolysis (X12).	$368.55
N285A	Major nerve exploration, decompression or neurolysis Not carpal tunnel or ulnar at elbow (X12).	$283.50
N188A	Minor nerve exploration or decompression Digital, cutaneous or lateral femoral cutaneous nerve (X12).	$153.70
N286A	Tumour or neuroma of a major nerve X12.	$317.85
N184A	Posterior tibial or common peroneal decompression X12.	$165.20

- Transposed the ulnar nerve? N189A pays $82.35 more than N190A and already includes the decompression (X12).
- Both carpal tunnels at once: the second side is paid at 85% (SP2 §3). A pre-op consultation for carpal tunnel surgery under local or IV sedation needs medical necessity in the chart (GP18).
- Operating microscope for a neurolysis, nerve tumour excision, suture, transfer or graft: E906A adds 40% (X12).
- Repeat peripheral nerve operation, or an acute nerve repair delayed more than 4 weeks: E925A adds 30% (X12).
- Nerve codes include any guidance, nerve stimulation or mapping (X13).

Acute brain injury management

G790A	First day You're the neurosurgeon most responsible for a critically ill in-patient with an acute brain injury (SAH, ICH, raised ICP, hydrocephalus, trauma). Limit: Once per admission (J88).	$223.10
G791A	Day 2 to day 30 Per day. Limit: 1 per day (J88).	$146.45
G792A	Day 31 onwards Per day. Limit: 1 per day (J88).	$58.60

- Covers the consult, daily assessments, ICP and coma management, family meetings and case conferences: no consult, assessment or time-based code the same day (J87–J88).
- Not payable after you or another neurosurgeon did an intracranial operation this admission, except Z820A, Z812A, N115A, N139A, N174A, Z824A, Z802A, Z825A or Z803A. An endovascular procedure by a non-neurosurgeon doesn't block it (J87).
- EVD or ICP monitor (Z820A) is on the exception list and is billed on top (J87, X5).
- You can't bill a critical care ICU per diem for the same patient the same day, and it isn't paid for stabilized patients, ICU or not (J88).
- Day 1: G790A pays $223.10 and includes the consult, so bill it instead of C045A ($145.60) when the patient is critically ill and you're most responsible (J87–J88).

In-patient or LTC consult

C045A	Consultation Requested by the attending physician, routine (not a called-in visit).	$145.60
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	$194.65
C046A	Repeat consultation	$64.85
C043A	Full work-up Specific assessment.	$64.90
C044A	Re-assessment Specific re-assessment. 2 per 12 months except admissions (GP23).	$33.40
C048A	Concurrent care You keep following the patient while another physician is the MRP. Limit: 4 in week 1, then 2 a week (GP48).	$31.00
W045A	Long-term care consultation Chronic care or convalescent hospital, nursing home, home for the aged (A147).	$145.60
W046A	Long-term care repeat consultation A147.	$64.85

- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2).
- Called in urgently instead (to a ward or long-term care)? Use the ED or ward tile: A-codes plus the premiums (A146–A147, GP65).
- Second surgeon brought in on consultation who then operates or assists may also claim the consult, justified on an IC basis (SP3 §8).
- Concurrent care is 4 claims in the first week and 2 a week after; it never takes E083A (GP47–GP48).

Hospital rounds

C122A	Day after admission, you're the MRP Once per admission (GP44).	$71.80
C123A	Second day after admission, you're the MRP Once per admission (GP44).	$71.80
C142A	First visit after transfer out of ICU, you're the MRP Patient was getting critical, ventilatory or comprehensive care and you didn't give it. One of C122A or C142A per admission (GP46).	$71.80
C143A	Second visit after transfer out of ICU, you're the MRP Same conditions. One of C123A or C143A per admission (GP46).	$71.80
C042A	Routine daily visit Weeks 1–5; then C047A (3 a week) and C049A (6 a month) (A146).	$31.00
C124A	Discharge day, you're the MRP Stay over 48 hours; discharge summary within 48 hours (GP45).	$71.80
C126A	Discharge day, complex patient Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes (A13).	$95.10
C121A	Extra visit for an acute intercurrent illness After week 5, when the weekly or monthly limit is used up (GP43).	$40.05

- As MRP after surgery, C122A and C123A pay $71.80 instead of $31.00 for the first two days (GP44).
- Patient came to your ward from the ICU? C142A and C143A pay $71.80 for your first two visits, in place of C122A/C123A (GP46).
- E083A adds 30% to your MRP visits (GP47). The E084A weekend premium isn't open to neurosurgery (GP47).
- Visit limits after week 5 count from the admission date if you admitted the patient, or from the referral date if referred in hospital (SP2).
- Surgery cancelled before induction counts as a subsequent visit; after induction with you scrubbed, bill E006A (SP7 §27).

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
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for day surgery or transfers within the hospital (GP42).	+30%
E083A	You're the MRP +30% on MRP subsequent visits. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).	+30%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the visit (GP103–GP104).	+50%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the visit (GP103–GP104).	+75%
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of this operation and any procedure ticked below (GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of this operation and any procedure ticked below (GP104).	+75%
E420A	Trauma patient with ISS over 15 (over 12 under age 16) +50% on this consult, assessment or operation and any procedure ticked, on the day of the trauma or within 24 h. ISS in the chart; same claim. Not on special visit or after-hours premiums (GP109).	+50%
A045A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2).	$145.60
A045A	Emergency consult that led to this surgery Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).	$145.60
A043A	Assessed your own patient before the surgery Specific assessment (SP2 §2).	$64.90
E901A	Used the operating microscope Only where listed: N102A, N103A, N151A, N152A, N153A, N105A, N154A, N106A, N155A, N129A, N266A, N267A, N211A, N213A (X1–X9).	$252.40
E902A	Lesion over 2 cm To N102A or N153A (X1).	$454.15
E905A	You also did the endonasal approach Turbinate reduction, antrostomy, ethmoidectomy, sphenoidotomy, septal work and flaps included (X10).	$750.00
E887A	Pituitary lesion extends to optic nerve, chiasm or hypothalamus To N111A or N114A (X10).	$500.00
E888A	Non-pituitary lesion extends to optic nerve, chiasm or hypothalamus To N116A (X10).	$500.00
E893A	Complex closure or reconstruction Lesion beyond the sella, CSF leak repair and pedicled flap over 3 cm; includes duroplasty. Not with E919A (X11).	$555.00
E892A	Harvested a pedicled vascular flap over 3 cm For a complex closure only (X11).	$500.00

E898A	Aneurysm over 2.5 cm X1.	$283.80
E979A	Clinoidal drilling, complex aneurysm X1.	$396.70
E908A	Also removed haematoma from a ruptured aneurysm Intracerebral and/or subdural (X1).	$304.30
E919A	Duroplasty over 2 cm To any intracranial procedure. Not with E893A (X1, X11).	$254.45
E921A	Repeat cranial procedure To any open intracranial procedure and N111A, N114A, N116A; not N127A (X1).	$262.15
E912A	Repaired a dural laceration With skull fracture reduction (X6).	$233.30
E368A	First disc excised To N509A, N510A, N520A, N511A or N512A. Not for the disc of an interbody fusion E372A (Z6, Z8).	$306.00
E361A	Each additional level decompressed Including disc excision, one or both sides (Z6).	$260.80
E360A	Each additional anterior level decompressed Z3.	$306.00
E365A	Anterior fusion with instrumentation or cage, one level Each more level: E366A (Z4).	$862.00
E363A	Anterior cervical fusion, no instrumentation, one level Each more level: E364A ($102.00) (Z4).	$357.00
E370A	Posterior instrumented fusion, one level Includes two levels of instrumentation. Each more level: E366A (Z1, Z7).	$880.15
E369A	Posterior fusion, no instrumentation, one level Each more level: E364A ($102.00) (Z7).	$255.00
E372A	Posterior interbody fusion (TLIF/PLIF), one level Cage or structural graft; includes the discectomy (Z8).	$510.00
E376A	Each additional interbody level Z8.	$255.00
E366A	Each additional instrumented level fused After E365A or E370A (Z4, Z7).	$153.00
E378A	3D navigation Tracked instruments on a navigation system with 3D reformats. Listed with fusion, fracture, odontoid screw and scoliosis codes. Live fluoro, CT or X-ray alone isn't paid (Z1, Z7, Z10).	$510.00
E379A	2D navigation Tracked instruments on a navigation system with 2D views. Listed with fusion, fracture, odontoid screw and scoliosis codes (Z1, Z7, Z10).	$510.00
E387A	Spinopelvic fixation (iliac or S2AI screws) L5–S1 fusion alone isn't spinopelvic (Z7–Z8).	$300.00
E374A	Foramen magnum decompression under 3 cm With the cervical decompression (Z6).	$357.00
E380A	Each additional laminoplasty level Z6.	$357.00
E382A	Spinal duroplasty Autologous, allogenic or synthetic (Z3, Z6).	$244.80
E383A	Acute spinal cord injury ASIA A–C, 6 weeks or less (Z1).	$255.00
E386A	Extradural cord or cauda equina decompression for tumour or infection +42% of the main decompression only (Z11).	+42%
E373A	Repeat decompression +30% of the main decompression (Z13).	+30%

E395A	Each additional level reduced Z10.	$306.00
E393A	Each additional kyphoplasty level Z10.	$510.00
N290A	Other side too (bilateral) Second side at 85% (SP2 §3).	+85%
E906A	Operating microscope +40% for neurolysis, nerve tumour excision, suture, transfer or graft (X12).	+40%
E925A	Repeat nerve operation, or repair delayed 4+ weeks +30% (X12).	+30%
K036A	Northern Health Travel Grant form Your part of the form for a patient travelling from Northern Ontario (A60).	$10.25
K070A	Home care referral form You're the most responsible physician sending the patient to home care. Once per home care admission (A58–A59).	$34.75
K730A	Phoned another physician for advice 10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test. Start and stop times charted. 1 a day (A42–A43).	$37.05
K738A	Sent an e-consult to another physician Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months (A48–A49).	$16.45
K708A	Discussed at a cancer conference (MCC) today Pre-scheduled MCC to Ontario Health standards, you took part (chair: K709A, $47.75). Payable the same day as a visit (A29).	$37.05
K121A	In-patient case conference, per unit Pre-scheduled, with the MRP and 2+ others, 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months (A31–A33).	$37.05

Did a procedure?

Z820A	EVD or ICP monitor inserted 1 per patient per day. Revision or replacement within 30 days: Z812A ($279.55) each (X5).	$395.85
Z804A	Lumbar puncture Includes image guidance and any drug injected (J83).	$150.00
Z944A	Lumbar drain (subarachnoid CSF drainage) Z15.	$89.75
Z821A	Shunt tap or injection into shunt Diagnostic or therapeutic agent (X8).	$53.10
Z801A	Non-operative shunt revision X8.	$51.50
Z802A	Ventricular puncture or cisternal tap Through previous burr hole or fontanelle (X4).	$81.65
Z803A	Subdural tap, one side X6.	$53.10
Z818A	Repeat abscess aspiration through existing burr hole Within 30 days (X4).	$215.35
Z943A	Programmed an infusion pump or spinal cord stimulator Z15.	$142.20
Z940A	Vertebral needle biopsy Z14.	$177.05
N556A	Facet medial branch or sacral lateral branch neurotomy, first site Z15.	$142.80
E396A	Each additional neurotomy site With N556A (Z15).	$71.40
N534A	RF dorsal root rhizotomy Any number of levels (Z15).	$379.45
Z815A	Temporal artery biopsy Or ligation (X7).	$200.00
Z176A + E542A	Scalp laceration up to 5 cm Layered or tying bleeders: Z154A ($39.35) (M15).	$34.55
Z101A + E542A	Wound abscess drained, local Outside hospital, with tray (M1).	$40.85

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	A045A, A935A, A046A, A043A, A044A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and its time can't count twice (J27, J28).
G521A,G523A,G522A,G395A,G391A	G400A, G401A, G402A	No	Critical care time codes aren't paid the same day as a critical care or ventilatory support per diem (J27–J28).
E078A	A043A, A044A	No	E078A is only paid to the specialties listed in GP25; Neurosurgery (04) isn't one of them (GP25).
A045A,A046A,A043A,A935A	Z804A, Z821A, Z801A, Z943A, Z940A, Z815A, Z944A	Sometimes	Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A044A) is payable before it that day (SP4 §13).
A044A	Z804A, Z821A, Z801A, Z943A, Z940A, Z815A, Z944A, Z101A, Z176A	Yes	A partial assessment is allowed before a planned Z-code procedure (SP4 §13).
A045A,A935A,A046A,C045A,C935A,C046A	N103A, N102A, N153A, N151A, N114A, N116A, N105A, N129A, N144A, N143A, N148A, N104A, N200A, N230A, N511A, N512A, N509A, N510A, N500A, N560A, N572A, N190A, N189A	Yes	The consult where you decide to operate is the major pre-operative visit: never included in the surgical fee, whenever the surgery happens (SP2, GP4).
A043A,A044A,C043A,C044A	N103A, N102A, N153A, N114A, N511A, N512A, N509A, N510A, N500A, N290A	Sometimes	Only when this is the visit where you decided to operate. A hospital or day-surgery admission assessment that isn't that visit isn't paid (SP2).
A045A,A935A,C045A,C935A	N290A	Sometimes	Your decision-to-operate consult is paid, but a pre-operative consultation for carpal tunnel surgery under local or IV sedation is only paid when the chart shows it was medically necessary (GP18).
N143A	N144A, N148A	No	Burr hole drainage isn't paid with N144A or N148A for the same craniotomy (X6).
E901A	N144A, N143A, N148A, N104A, N200A, N511A, N512A, N509A, N510A, N500A	No	E901A is only listed with the tumour, aneurysm, AVM, Chiari, cranial nerve and orbital craniotomies (X1–X9), and the microscope is part of every spinal code (Z2).
E921A	N127A	No	The repeat cranial procedure premium excludes N127A (X1).
E919A	E893A	No	E919A isn't paid with complex closure E893A, which includes duroplasty (X11).
N111A,N114A,N116A,N112A	M061A, M083A, Z350A, M054A, Z351A	No	No Respiratory Surgical Procedures services are paid with N111A, N112A, N114A or N116A (X10).
M061A	N111A, N114A, N116A	No	M061A isn't paid for the approach to the pituitary fossa as part of N111A, N112A, N114A or N116A (P5).

Code	With	Together?	Why
E889A,E890A,E891A	E887A, E888A	Sometimes	E889A–E891A are only paid with E887A or E888A, to a surgeon with a skull base fellowship or equivalent (X11).
N123A	N124A	No	Stereotaxis N123A with functional stereotaxy N124A is payable at nil (X4).
N200A	N153A	Sometimes	Submit with the manual review indicator and supporting documents (X1, X6).
G790A,G791A,G792A	A045A, A935A, A046A, A043A, A044A, C045A, C935A, C046A, C043A, C044A, K121A	No	No consultation, assessment, time-based service or case conference for the same patient the same day (J88).
G790A,G791A,G792A	G400A, G401A, G402A	No	Critical care ICU per diems aren't paid with G790A–G792A for the same patient, same day, same physician (J88).
G790A,G791A,G792A	N103A, N102A, N144A, N148A, N104A, N200A, N230A, N143A	Sometimes	Only before the operation: once a neurosurgeon has done an intracranial procedure that isn't on the J87 exception list, brain injury management isn't paid to anyone for that post-operative patient (J87).
G790A,G791A,G792A	Z820A, Z812A, N115A, N139A, Z802A, Z803A	Yes	These procedures are on the J87 exception list, so brain injury management stays payable (J87).
G790A	G791A, G792A	No	One per diem a day: G790A on day 1, G791A days 2–30, G792A from day 31 (J88).
N521A,N522A	N511A, N512A, N509A, N510A, E368A, E370A, E372A	No	Re-opening a laminectomy isn't paid with any other spinal code except duroplasty E382A (Z6).
N521A	N522A	No	N521A isn't paid with N522A (Z6).
E372A	E368A	Sometimes	E372A includes the discectomy, so E368A isn't added for the disc you fused (Z8).
E372A,E376A	N540A, E389A	Sometimes	Only at a different spinal level: interbody fusion isn't paid with scoliosis correction at the same level (Z8).
N560A	N561A	No	N560A isn't paid with N561A (Z11).
N560A,N561A	N509A, N510A, N511A, N512A, E361A	No	No other decompressive codes are paid with intradural tumour removal (Z11).
N572A	N509A, N510A, N511A, N512A	Sometimes	Decompression at the fracture level is included in the open reduction; a different level may be billed. Fusion is paid on top (Z10).
N573A	E370A, E365A, N572A, E383A	No	Only navigation E378A/E379A is paid with odontoid screw N573A (Z10).
N583A	E370A, N572A, N510A, N512A, E392A	No	Only E393A is paid with kyphoplasty N583A (Z10).
N570A	E370A, N572A, N510A, N512A, E388A	No	Only E391A is paid with vertebroplasty N570A (Z10).
N526A,N525A	N500A, E365A, E360A, E366A	No	Only E394A is paid with an artificial disc (Z4).
N530A	N509A, N510A, N511A, N512A	No	Spinal cord stimulator electrode by laminectomy isn't paid with decompressive codes (Z15).
N548A	N550A	No	Incision and drainage is included in sequestrectomy N550A (Z11).
E370A	E384A	Sometimes	E370A claimed with E384A is reduced to E366A (Z7).
N189A	N190A	No	N189A 'may include' exploration, decompression and neurolysis, so when done they are part of N189A (X12, GP4).
N188A,N285A	R585A, E581A	No	Through the same incision as a flexor tendon repair, the nerve exploration is payable at nil (X13).

Code	With	Together?	Why
N282A	N283A	Sometimes	Only when a complete brachial plexus neurolysis is done in addition to the rib excision and scalenectomy (X12).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).
E420A	E409A, E410A	Yes	E420A isn't applied to the after-hours premium, but the after-hours premium is still payable (GP109).
K036A,K070A,K730A, K738A	A045A, A935A, A046A, A043A, A044A, C124A, C126A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K070A with the assessment (A58); K730A and K738A with visits the same day (A42, A48).
K708A,K709A,K121A	A045A, A935A, A046A, A043A, A044A, C042A, C122A, C123A, C124A, C126A	Yes	Only services rendered during the conference are not paid; a visit outside it the same day is (A29, A32).
K708A	K709A	No	Only one of K708A, K709A, K710A or K711A per physician per day (A29).
C122A	C124A, C126A, C042A	No	One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
E083A	C048A	No	E083A is only for the MRP's own subsequent visits (GP47).
E083A	C042A, C047A, C049A, C122A, C124A, C982A	Yes	E083A applies to the MRP's subsequent visits, C121A–C126A, C142A, C143A and C982A (GP47).
E084A	C042A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Neurosurgery (04) isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026); pages in brackets. Totals are your fee only (suffix A): the surgical assistant bills the Asst units × $12.91 and the anaesthetist the Anae units × $15.96, plus time units, with suffix B or C (GP85, GP92). In spinal surgery the main N-code is paid in full and each further N-code at 85% (Z1, SP2 §3); totals leave that out unless you tick it, and leave out any procedure entered outside the procedure list. Age premiums for patients under 16 on consults and surgery are added by OHIP on the remittance (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.