

Obstetrics and Gynaecology OHIP Billing Cheat Sheet 2026

OHIP specialty 20 · Prenatal or postnatal visit · Delivery · Colposcopy · Updated October 2026

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

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

Office consultation

A205A	Consultation Written referral from a physician or NP; send a written report back. Includes a cervical biopsy, Pap/HPV specimen and wet mount if done (A151). Limit: 1 per patient per 2 years for the same diagnosis (GP17).	\$134.25
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart review. Chart start and stop times (GP19–GP20).	\$194.65
A206A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	\$71.45

- 50+ minutes face to face? A935A pays \$194.65, \$60.40 more than A205A. Time spent on procedures and charting doesn't count (GP19–GP20).
- 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).
- A cervical biopsy at a consult or specific assessment is included (A151 note). Bill biopsies through colposcopy codes instead.
- Pregnant patient referred for complexity: bill the consult, then P004A for each prenatal visit (K2).
- Pelvic exam with speculum in the office adds E432A (\$5.00). Not when you bill E430A, E431A or E542A that day (A150).

Office follow-up

A204A	Follow-up visit History of the problem, the exam needed, advice. Partial assessment.	\$40.50
A203A	Full work-up of one problem Full history of the complaint and detailed exam of the affected system. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	\$62.65
A920A	Medical management of early pregnancy loss or termination Assessment plus giving the medication (drug cost not included). No consult, assessment or counselling the same day (K4).	\$193.70
A922A	Medical management of ectopic pregnancy Assessment plus giving methotrexate or similar. No consult, assessment or counselling the same day (K4).	\$249.75
A921A	Follow-up after A920A or A922A By you or another physician. No other assessment the same day. Limit: 2 per pregnancy (K5).	\$44.55

- Your office has no specific re-assessment code: routine follow-ups are A204A. A203A is limited to 1 a year per patient (2 for a clearly different diagnosis) (GP23).
- Pap at an A204A: bill G365A + E430A (\$23.95), or G394A + E431A for an additional screen. At an A203A the specimen is included: bill E430A or E431A alone (A150, J47).
- Doing a procedure today you decided on at an earlier visit? A204A is the only visit payable before a Z-code procedure that day (SP4 §13).
- A920A or A922A replaces the visit: nothing else for assessment or counselling that day (K4).
- E078A (chronic disease premium) isn't payable to obstetrics and gynaecology (20): GP25 limits it to geriatrics, endocrinology, neurology, paediatrics, pathology, physical medicine, radiation oncology, medical oncology, infectious disease, respirology, rheumatology, haematology and clinical immunology, so OHIP won't pay it.

Prenatal or postnatal visit

P004A	Routine prenatal visit Monthly to 28 weeks, every 2 weeks to 36, then weekly (K2).	\$44.55
P003A	First prenatal visit, full exam Full history and exam of all systems. For a patient transferred to you for uncomplicated care, or whose care you start. Not after another general assessment for this pregnancy (K2).	\$93.85
P002A	High-risk prenatal visit (MFM) Maternal-fetal medicine specialist, 20+ minutes face to face for a documented significant risk. Chart start and stop times (K4).	\$87.25
P008A	Postnatal visit in the office Pap specimen at this visit is included; E430A still applies.	\$43.80
P007A	Postnatal care in hospital or at home First postpartum check of a well patient, plus later ones until the first office visit (K1).	\$65.55
• P005A (\$55.70) pays \$0 on the same day as a consult or any visit other than P003A or P004A. If you saw her today as a consult, do the risk review at the next P004A (K4). • Paid on top of the prenatal visit: a non-stress test for a high-risk pregnancy (P025A, written report), a urine dip read in your office (G010A, result and decision charted), and each injection given (G372A) (K10, J65, J54). • Pregnancy-related illness or false labour visits are billed as assessments per visit, even if she delivers within 2 days. Not when she's admitted in first-stage labour (K2 §3, §6). • A visit for a problem unrelated to the pregnancy, apart from a routine prenatal visit, is billed as the usual assessment (K2 §4). • Referred for complexity? The first visit is your consultation (Office consultation tile), then P004A for each prenatal visit (K2 §2).		

Delivery

P006A	Vaginal delivery Includes 1st and 2nd degree tear or episiotomy repair (K6).	\$512.65
P020A	Operative vaginal delivery Forceps or vacuum, breech, or shoulder dystocia with advanced maneuvers (K6).	\$535.60
P018A	Caesarean section	\$579.80
P041A	Caesarean section with tubal ligation Don't add S741A separately.	\$609.20
P042A	Caesarean hysterectomy	\$1,004.60
P010A	Attended another physician's delivery as the obstetric consultant Called to attend. Not when the patient was transferred to that physician for normal care (K3 §10).	\$211.20
• Delivery between 17:00 and 07:00, or on a weekend or holiday? Tick E409A (+50%) or E410A (+75% at night) on the delivery fee (GP103–GP104). • Weekday daytime and you left booked office patients? Add C989A (\$78.55) for the first delivery of the day (K7). • Your only delivery today? E411A doubles the delivery fee, up to 25 per fiscal year (K7). • Twins: second vaginal baby is 85% of P006A or P020A; second baby by C-section is E499A (\$397.75); each baby from the third is E500A (\$148.60). At 20–23 weeks: one fee only (K6). • 3rd degree tear P045A (\$82.15), 4th degree P046A (\$200.00). Superficial transverse perineal muscle repair is a 2nd degree tear and is included (K8).		

Colposcopy

Z731A	First colposcopy for an abnormal screen or lesion Cervix, vagina or vulva, with or without biopsies (V6).	\$53.50
Z787A	Follow-up colposcopy with biopsy	\$53.50
Z730A	Follow-up colposcopy, no biopsy	\$28.35
• Colposcopy includes the Pap/HPV specimen: G365A and G394A are not paid, but the E430A or E431A add-on is (\$11.95) (V6, J47). • Cervical biopsy Z720A is not paid with a colposcopy code (V6). • First visit from the referral: bill the consult as well when it's the visit where you decided on colposcopy. At a later colposcopy, only a partial assessment (A204A) can go before it that day (SP4 §13). • A colposcopic look done only as part of your exam (screening) is included in the assessment (V6). • LEEP (Z766A), laser or cryo conization (Z729A) and cryotherapy (Z732A) are in the procedure list below.		

Procedure only

- Planned procedure, decided at an earlier visit: only a partial assessment (A204A) is payable before a Z-code procedure that day (SP4 §13).
- Pap, contraceptive implant or laminaria the only reason for the visit: add G700A (\$8.80) once. Not for an IUD, pessary or biopsy alone (not (+) procedures), and not with an assessment that day (J3).

- Endometrial biopsy in the office with a paracervical block: Z770A + E542A + E861A = \$60.50 (V7).
- Tray fee E542A (\$12.65) goes on listed codes only (IUD, endometrial, vulvar and vaginal biopsy, Bartholin I&D) and only outside hospital.
- IUD removal isn't paid the same day as an insertion (J46).

Called to ED, L&D or ward

A205A	Consultation Requested by the ED or ward physician. Written report.	\$134.25
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	\$194.65
A206A	Repeat consultation Same problem, new request, after another physician's care in between.	\$71.45
A203A	Full work-up, your own patient Specific assessment.	\$62.65
A204A	Brief assessment Partial assessment.	\$40.50

- Use A-prefix codes plus the premiums when called in non-electively, not C-codes (GP43, GP65).
- The premiums shown are the ED table (I). For an in-patient on a ward (table III, C9xx) or out-patient/L&D triage (table II, U9xx) the amounts are the same; bill that table's codes (GP71–GP72).
- No premiums for patients you see on rounds, for elective admissions, or for non-referred obstetric patients; C989A is the only exception (GP65).
- Took her to the OR from here? Bill the procedure from the Surgery or Delivery tile too, with E409A/E410A after hours (SP2 §2).

In-patient consult

C205A	Consultation Requested by the attending physician, routine (not a called-in visit).	\$134.25
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	\$194.65
C206A	Repeat consultation	\$71.45
C203A	Full work-up Specific assessment.	\$62.65
C204A	Re-assessment Specific re-assessment. 2 per 12 months except admissions (GP23).	\$44.30

- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2, GP40).
- Elective surgical admission and you did a pre-op assessment in the last 30 days: no admission assessment (GP41).
- Called in urgently instead? Use the ED, L&D or ward tile for A-codes and premiums.

Hospital rounds

C122A	Day after admission, you're the MRP Once per admission. Not for delivery admissions (GP44).	\$71.80
C123A	Second day after admission, you're the MRP Once per admission. Not for delivery admissions (GP44).	\$71.80
C202A	Routine daily visit 1 a day in weeks 1–5; then C207A (3 a week) and C209A (6 a month).	\$31.00
C124A	Discharge day, you're the MRP Stay over 48 hours; discharge summary within 48 hours. Not for delivery admissions unless she was in ICU (GP45).	\$71.80
C126A	Discharge day, complex patient Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes (A13).	\$95.10
C142A	First visit after transfer out of the ICU, you're the MRP She got critical care, ventilatory or comprehensive care just before transfer (not monitoring only), and you didn't give it. Instead of C122A: one of C122A/C142A per admission (GP46).	\$71.80
C143A	Second visit after transfer out of the ICU, you're the MRP Instead of C123A: one of C123A/C143A per admission. Not the same day as C124A or C126A (GP46).	\$71.80
C208A	Concurrent care You follow the patient while another physician is the MRP.	\$31.00

- As MRP after surgery, C122A and C123A pay \$71.80 instead of \$31.00 for the first two days (GP44). Came to you from the ICU? C142A/C143A take their place (GP46).
- E083A adds 30% to your MRP visits; surgeons qualify (GP47). E084A weekend premium is not open to Obstetrics and Gynaecology (GP47).
- Post-op visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Delivery admissions don't get C122A, C123A or C124A (GP44–GP45); use C202A or P007A.
- After week 5, an acute intercurrent illness is C121A (\$40.05), outside the weekly limits (GP43). Palliative care visits as MRP: C982A \$40.05, and E083A applies to it (GP47, GP50).

Surgery (OR)

S757A	Abdominal hysterectomy Total or subtotal, with or without adnexa. Laparoscopic: tick E862A.	\$643.35
S816A	Vaginal hysterectomy With or without adnexa. Laparoscopic-assisted: tick E862A.	\$643.35
S738A	Salpingectomy or salpingo-oophorectomy One or both sides. Not with a hysterectomy (V8).	\$366.20
Z587A	Hysteroscopic resection of polyps or fibroids With or without D&C. One hysteroscopy code per day (V7).	\$206.35
S784A	Ectopic pregnancy, surgical Any technique. D&C not paid with it (V1).	\$462.20
S768A	D&C for incomplete miscarriage	\$113.40

- Laparoscopic or laparoscopic-assisted hysterectomy: E862A adds 25% (V8).
- Salpingectomy, oophorectomy, tubal ligation and vault repairs aren't paid with a hysterectomy (V8). Composite operations pay the major procedure only (V1).
- The decision-to-operate visit is always billed separately, whenever it was. The day-surgery or admission assessment isn't, unless it was that visit (SP2).
- Second procedure under the same anaesthetic: 85% of its fee (SP2 \$3). Converted from laparoscopy to laparotomy: add E860A (SP5 \$23).
- Non-elective case started after 17:00 weekdays, on a weekend or holiday: E409A +50%; 00–07: E410A +75% (GP104). E400/E401 are the assistant's and anaesthetist's versions, not yours.

Phone or e-consult

K731A	A doctor or NP phoned you for advice 10+ min of patient discussion, start and stop times charted, their billing number on the claim. Not to arrange a visit, transfer or test, or mainly to go over results (A42–A44). Limit: 1 per patient per day; \$0 if you see the patient that day or the next.	\$47.75
K739A	You answered an e-consult Request and answer through a secure server, answer within 30 days, the requester's billing number on the claim (A48–A50). Limit: 1 a day and 6 per patient per 12 months, any physician; \$0 if you see the patient that day or the next.	\$20.50
K730A	You phoned another doctor for advice You keep caring for the patient. 10+ min, times charted. Also paid on top of a visit the same day (A42–A43). Limit: 1 per patient per day.	\$37.05
K738A	You sent an e-consult Paid once the other doctor answers within 30 days. Also paid on top of a visit the same day (A48). Limit: 1 a day and 6 per patient per 12 months.	\$16.45

- A family doctor's call about a patient you don't see: K731A pays \$47.75 for 10+ minutes. Chart start and stop times and put their billing number on the claim (A43–A44).
- See the patient that day or the next and K731A or K739A pays \$0; bill the consult or visit instead (A43, A49).
- Not paid when the call or e-consult is mainly to book a consult or procedure, arrange a transfer, or discuss test results (A43, A48–A49).
- Calling or e-consulting someone else about your own patient: K730A or K738A is paid on top of that day's visit (A42, A48).

Also bill, if it's true

E432A	Pelvic exam with speculum in the office With A203A–A206A, outside hospital, done personally. Once a day. Not with E430A, E431A or E542A (A150).	\$5.00
G365A + E430A	Pap / HPV screen Age 25+, none in the last 33 months (J47).	\$23.95
E430A	Pap / HPV screen (specimen included in this visit) Only the out-of-hospital add-on is paid with a consult, specific assessment, postnatal visit or colposcopy (A150, J47).	\$11.95
E431A	Extra cervical screen for a listed reason (specimen included) Follow-up after low grade or HPV result, immunocompromised, invalid test, post-hysterectomy dysplasia. Chart the reason (J47).	\$11.95
G394A + E431A	Extra cervical screen for a listed reason Follow-up after low grade or HPV result, immunocompromised, invalid test, post-hysterectomy dysplasia. Chart the reason. A partial assessment or minor prenatal visit doesn't include the specimen, so G394A is paid too (J47).	\$23.95
G365A + E430A	Pap / HPV screen Age 25+, none in the last 33 months. The only reason for the visit: add G700A (J3, J47).	\$23.95
G394A + E431A	Extra cervical screen for a listed reason Follow-up after low grade or HPV result, immunocompromised, invalid test, post-hysterectomy dysplasia. Chart the reason (J47).	\$23.95
G700A	The Pap, implant or laminaria was the only reason for the visit Once per visit, with procedures marked (+): Pap G365A/G394A, implant G318A, laminaria G362A. Not for an IUD, pessary or biopsy alone; not in hospital; not when you bill an assessment that day (J3).	\$8.80
K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a referral, visit or test, or mainly to discuss results. Paid on top of the visit (A42–A43).	\$37.05
K738A	Sent an e-consult Paid once the other doctor answers within 30 days. Max 1 a day and 6 per patient per 12 months. Paid on top of the visit (A48).	\$16.45
K036A	Filled in a Northern Health Travel Grant form Payable 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 already on home care. Paid on top of the visit (A58–A59).	\$34.75
K121A	Hospital in-patient case conference, per 10-min unit Pre-booked, MRP plus 2+ others (physicians, regulated social workers or health professionals). 10 min = 1 unit, 16 = 2, 26 = 3, 36 = 4. Max 4 per 12 months, 8 units a day. Your visit that day is paid too, if not during the conference (A31–A33).	\$37.05
P005A	Did the antenatal risk review Psychosocial, genetic and medical, written in the chart. Once per pregnancy, by the MRP (K4).	\$55.70
P025A	Non-stress test with interpretation High-risk pregnancy only; written report. 1 a day (K10).	\$9.65
C989A	Left booked office patients to do this delivery Weekday 07–17, first delivery of the day. Also allowed for a transferred patient (K7, GP78).	\$78.55
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of this procedure and any procedure ticked below (GP104).	+50%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the consult (GP103–GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of this procedure and any procedure ticked below (GP104).	+75%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the consult (GP103–GP104).	+75%
E411A	Your only delivery today +100% of the delivery fee (and of E414A). Max 25 per fiscal year (K7).	+100%

E414A	High-risk delivery Under 32 weeks, severe PIH, IUGR under 10th percentile, or absent/reversed umbilical flow (K8).	\$62.05
E502A	Trial of labour after caesarean (VBAC) Successful or not (K6).	\$51.00
P006A	Second baby delivered vaginally 85% of that baby's own code (P006A or P020A). Not counted if stillborn (K6).	+85%
E499A	Second baby by caesarean K6.	\$397.75
E500A	Third and each further baby Each baby. Not at 20–23 weeks (K6).	\$148.60
P045A	Repaired a 3rd degree tear Must include the anal sphincter and perineum (K8).	\$82.15
P046A	Repaired a 4th degree tear Rectal mucosa, sphincter and perineum (K8).	\$200.00
Z774A	Postpartum haemorrhage: explored and curetted Exploration of vagina and cervix, uterine curettage (K8).	\$113.65
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for delivery admissions or day surgery; not if the hospital pays you for in-patient work (GP42).	+30%
E083A	You're the MRP +30% on MRP subsequent visits, C121A, C122A–C126A, C142A, C143A and C982A. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).	+30%
A205A	Also the referral consult (decided on colposcopy today) Payable with the colposcopy when this is the decision visit (SP4 §13).	\$134.25
A204A	Also a brief assessment before the procedure Partial assessment. The only visit allowed before a planned Z-code procedure when you decided on it at an earlier visit (SP4 §13).	\$40.50
A205A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2). Nothing else before the procedure that day.	\$134.25
A204A	Brief assessment before a planned Z-code procedure Decision visit was in the last 12 months (SP4 §13).	\$40.50
E862A	Done laparoscopically or laparoscopic-assisted +25% (V8).	+25%
E090A	Removed ovaries for moderate or severe endometriosis With S757A, S758A or S759A (V8).	\$260.80
E854A	Ureterolysis, each side Pararectal and paravesical spaces defined, uterine vessels identified, pelvic ureter mobilised (V1).	\$170.00
E860A	Started laparoscopically, converted to open Or diagnostic laparoscopy before laparotomy (SP5 §23, V1).	\$131.45
E676A	BMI over 40, general anaesthetic +25%, once per patient. BMI charted; open or laparoscopic pelvic surgery (SP6–SP7).	+25%
E673A	60+ minutes of adhesiolysis Less than 60 minutes is included (SP7).	\$124.10

Did a procedure?

G378A + E542A	IUD insertion	\$60.15
G552A + E542A	IUD removal Not the same day as an insertion (J46).	\$36.45
Z770A + E542A	Endometrial biopsy	\$51.50
Z770A + E542A + E861A	Endometrial biopsy with paracervical block E861A is paid for your own block in the office (V7).	\$60.50
Z720A	Cervical biopsy or polyp, not at colposcopy Included in a consult or specific assessment (A151).	\$20.00
Z477A + E542A	Vulvar biopsy, local	\$52.25
Z722A + E542A	Vaginal biopsy, local	\$52.25
Z714A + E542A	Bartholin or vulvar abscess drained, local	\$38.05
Z733A	Vulvar warts, chemical or cryo One or more.	\$12.00
Z736A	Vulvar warts, excision or laser, local	\$32.60
G398A	Pessary fitting 1 per 12 months (J48).	\$65.35
G550A	Pessary care: removed, cleaned, reinserted Up to 6 per 12 months; not with G398A (J48).	\$10.00
Z766A	LEEP	\$85.65
Z729A	Cryo, electro or laser conization Premalignant lesion, out-patient.	\$38.35
Z732A	Cervical cryotherapy	\$17.30
Z724A	Cervical electrocautery	\$8.55
G318A	Contraceptive implant insertion Removal: Z114A (M1).	\$42.00
Z114A + E542A	Contraceptive implant removal M1.	\$40.30
Z778A	Amniocentesis	\$102.00
Z777A	External cephalic version In hospital, after 35 weeks, once per pregnancy (K10).	\$60.35
P023A	Oxytocin induction or augmentation Once per pregnancy, for a recognized complication; no detention (K2 §9).	\$67.75
P030A	Cervical ripening Once per pregnancy; \$0 with a consult or visit the same day (K10).	\$58.60
G372A	Injection with the visit Each intramuscular, subcutaneous or intradermal injection, on top of the visit (J54).	\$4.55
G373A	Injection was the only reason for the visit First injection; each extra one is G372A (\$4.55). Not with an assessment (J54).	\$7.90
G010A	Urine dip read in your office No microscopy. Chart the result, your reading and the treatment decision (J65, J68).	\$2.64
G012A	Wet mount read in your office Included in a consultation, repeat consultation or specific assessment (A151 note); paid with A204A, prenatal visits and procedures. Chart the result and decision (J65, J68).	\$1.93
G005A	Office pregnancy test Only when an immediate answer is needed to prevent imminent physical harm (J67).	\$3.88

Can I bill these together?

Code	With	Together ?	Why
J168	J157, J158, J159, J160, J162, J163, J138, J161, J164	No	No other abdominal, pelvic or pregnancy ultrasound is paid the same day as the nuchal translucency scan, by any physician (G5).
J165	J138, J161	No	J138 and J161 with sonohysterography are paid at nil (G6).
E078A	A203A, A204A, A920A, A921A, A922A	No	E078A is only paid to the specialties listed in GP25; Obstetrics and Gynaecology (20) isn't one of them (GP25).
E432A	E430A, E431A, E542A	No	E432A is not paid with E430A, E431A or E542A (A150).
E432A	A205A, A206A, A203A, A204A	Yes	E432A adds to A203A, A204A, A205A and A206A when the pelvic exam is done outside hospital (A150).
G365A,G394A	A205A, A935A, A206A, A203A, P003A, P008A, Z731A, Z787A, Z730A	No	The Pap specimen is included in this service; bill the E430A or E431A add-on alone (A150, J47, V6).
G365A,G394A	A204A, P004A	Yes	A partial assessment and a minor prenatal visit aren't on the J47 list of services that include the specimen, so G365A or G394A is paid with its add-on (J47 rule 4).
G012A	A205A, A206A, A203A, C205A, C206A, C203A, C204A, W305A, W306A	No	Examining a trichomonas (wet) preparation is included in this consultation or assessment (A151 note).
G700A	A205A, A935A, A206A, A203A, A204A, P002A, P003A, P004A, P008A, A920A, A921A, A922A	No	G700A is only for a visit where a (+) procedure was the sole reason; not when a consultation or assessment is paid that day (J3).
G373A	A205A, A935A, A206A, A203A, A204A, P002A, P003A, P004A, P008A	No	G373A is for an injection that was the only reason for the visit; with a visit, bill G372A (J54).
G373A	G372A	Yes	Sole-reason visit: G373A for the first injection, G372A for each additional one (J54).
K731A,K739A	A205A, A935A, A206A, A203A, A204A, P002A, P003A, P004A, P008A, A920A, A921A, A922A, C205A, C935A, C206A, C203A, C204A	No	Phone or e-consult advice pays \$0 when you see the patient for a consultation, assessment or visit the same day or the next (A43, A49).
K730A,K738A	A205A, A935A, A206A, A203A, A204A, P002A, P003A, P004A, P008A, C202A, C122A, C123A, C124A, C126A	Yes	The referring doctor's phone or e-consult is paid in addition to visits the same day (A42, A48).
P025A	P004A, P003A, P002A, A203A, A204A	Yes	The non-stress test is its own listed service, not part of the visit: high-risk pregnancy, trace interpreted, written report, 1 a day (K10).
P030A	P023A	Yes	Cervical ripening is payable in conjunction with P023A (K10).
P023A	P006A, P020A, P018A, P041A, P042A	Yes	Medical induction or augmentation is listed separately from the delivery: once per pregnancy, for a recognized obstetrical complication, no detention (K2 \$9, K10).
Z774A	P006A, P020A	Yes	Exploration and curettage for postpartum haemorrhage is a separate listed service, not part of the delivery fee (SP2 \$1, K8).
E430A	A205A, A206A, A203A, P008A, Z731A, Z787A, Z730A	Yes	The add-on is paid when the screen is collected outside hospital, even though the specimen itself is included (J47).
Z720A	A205A, A206A, A203A	No	Cervical biopsy is included in the consultation, repeat consultation and specific assessment (A151 note).
Z720A	Z731A, Z787A, Z730A	No	Z720A is not paid with a colposcopy code (V6).
Z731A,Z787A	Z730A	No	One colposcopy per visit; Z787A is the follow-up with biopsy, Z730A without (V6).

Code	With	Together ?	Why
A205A,A206A,A203A,A935A	Z731A, Z787A, Z730A, Z770A, Z766A, Z729A, Z587A, Z722A, Z477A	Sometimes	Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A204A) is payable before it that day (SP4 §13).
A204A	Z731A, Z787A, Z730A, Z770A, Z766A, Z729A, Z722A, Z477A	Yes	A partial assessment is allowed before a planned Z-code procedure (SP4 §13).
G552A	G378A	No	IUD removal isn't paid the same day as an insertion (J46).
G398A	G550A	No	Pessary care isn't paid the same day as a fitting (J48).
P005A	A205A, A206A, A203A, A204A, P002A, P008A	No	P005A pays \$0 with any consult or visit the same day except P003A and P004A (K4).
P005A	P003A, P004A	Yes	P005A can go with P003A or P004A (K4).
A920A,A921A,A922A	A205A, A206A, A203A, A204A, P004A	No	No consultation, assessment or counselling the same day as A920A, A921A or A922A (K4–K5).
P030A	A205A, A203A, A204A, P004A	No	Cervical ripening pays \$0 with a consult or visit by you the same day (K10).
C989A	E409A, E410A	No	C989A is for weekday daytime deliveries (07–17); E409A and E410A cover evenings, nights, weekends and holidays (GP78, GP104).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).
E411A	P042A	No	E411A adds to P006A, P009A, E414A, P018A, P020A, P038A or P041A only (K7).
E499A	P006A, P020A	No	E499A is the second caesarean baby, only with P018A, P041A or P042A (K6).
P045A,P046A	P006A, P020A	Yes	3rd and 4th degree repairs are paid on top; 1st and 2nd degree are included in the delivery (K6, K8).
S738A,S741A,S745A	S757A, S816A	No	Salpingectomy, oophorectomy and tubal occlusion are not paid with a hysterectomy (V8).
E862A	S757A, S816A	Yes	+25% when the hysterectomy is laparoscopic or laparoscopic-assisted (V8).
Z587A	Z582A, Z583A, S772A	No	Only one hysteroscopy code per day, and none with endometrial ablation (V7).
S754A	S757A, S816A, S784A	No	A D&C is not paid with a hysterectomy or with surgery for ectopic pregnancy (V1).
C122A	C124A, C126A, C202A	No	One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).
C123A	C124A, C126A	No	C122A and C123A aren't paid the same day as C124A or C126A (GP44).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as C124A or C126A (GP46).
C122A	C142A	No	Only one of C122A or C142A per hospital admission (GP44, GP46).
C123A	C143A	No	Only one of C123A or C143A per hospital admission (GP44, GP46).
C124A	C126A	No	Only one of C124A or C126A per hospital admission (A13).
S724A	P006A, P020A, S716A, S717A, S718A, S719A, S722A	No	Perineorrhaphy isn't paid with a delivery or other vaginal surgery (V4).
E083A	C208A	No	E083A is only for the MRP's own subsequent visits (GP47).
E084A	C202A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Obstetrics and Gynaecology isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026); pages in brackets. Ultrasound fees shown are the reading (professional) part, billed with suffix C; the technical part is paid only at a hospital or a hospital-run site (G1–G2). 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). Totals leave out the 85% rule for a second procedure under the same anaesthetic (SP2) and 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.