

Ophthalmology OHIP Billing Cheat Sheet 2026

OHIP specialty 23 · Routine eye exam · Optometrist referral · Injection, laser or minor procedure · Updated October 2026

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

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

Office follow-up

A234A	Partial assessment History of the complaint, the exam needed, advice. Most follow-ups.	\$31.95
A233A	Specific assessment Full history of the complaint and detailed exam of the eyes. Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$60.50
A251A	Special ophthalmologic assessment Developmental delay, learning or physical disability, or psychological problem that limits the exam; 20+ min face to face; vision care plan and written report to the care team. Chart start and stop times. Limit: 2 per 12 months.	\$125.80
A250A	Retinopathy of prematurity Baby 9 months or younger, or 10 months to 16 years with stage 3+ ROP.	\$125.80
A252A	Initial vision rehabilitation Low vision, field defect or oculomotor problem not treatable further; 4 of the 8 listed components. Limit: 2 per 5 years.	\$251.65
A254A	Follow-up vision rehabilitation 3 of the 8 components; only after an A252A. Limit: 10 per 5 years.	\$125.80

- A233A is 1 per patient per 12 months (2 with a clearly different diagnosis); more are cut to a lesser fee, so routine follow-ups are A234A (GP23).
- Child 15 or under with strabismus or amblyopia needing glasses: add E423A manual cycloplegic refraction (\$25, max 2 a year). Child 10 or under in active amblyopia treatment: add E424A (\$50, diagnostic code 368) (A155).
- A233A and A234A earn the under-16 age premium (10–30%), added by OHIP (GP64).
- Retinal photography is part of the visit and isn't billed separately (A154).
- A250A, A251A, A252A and A254A allow no other consultation or assessment by you that day (A156, A157, A161).
- E078A (chronic disease premium) isn't payable to ophthalmology (23): 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.

Office consultation

A235A	Consultation Written, signed referral on the chart; written report back (GP16). Limit: 1 per 24 months for the same diagnosis.	\$86.25
A935A	Special surgical consultation All the parts of a consult and 50+ min face to face, not counting procedures or chart work. Chart start and stop times.	\$194.65
A236A	Repeat consultation Same problem, new written referral, after another doctor cared for the patient in between (GP19).	\$48.00
A231A	Neuro-ophthalmology consultation Neuro-ophthalmology fellowship; neuro-ophthalmic disorder; 4 of: pupils, motility, alignment, neuro exam, fundus, formal field analysis, imaging review.	\$155.45
A930A	Uveitis consultation Uveitis fellowship; uveitis or ocular or orbital inflammation; dilated fundus exam plus review of labs and imaging.	\$157.00

- 50+ minutes face to face pays A935A (\$194.65), more than double A235A (\$86.25). Write start and stop times (GP19, GP7).
- Pre-op consult before cataract surgery under local is paid only when the chart shows it was medically necessary (GP18).
- Diagnostic tests (fields, OCT, angiography) are paid on top of the consult. Tonometry (G435A) is not (J89).
- OCT needs a consult or assessment by you for the same condition, but not necessarily the same day. Not for cataract work-up (J93–J94).
- One consult per patient per 24 months for the same diagnosis; extras are paid as A233A (GP17).

Routine eye exam

A239A	65 or older Periodic eye exam: refraction, acuity, motility, slit lamp, ophthalmoscopy, tonometry, prescription. Limit: 1 per 12 months, any doctor or optometrist.	\$59.35
A237A	19 or younger Periodic eye exam. Limit: 1 per 12 months, any doctor or optometrist.	\$59.35
A115A	20 to 64, with an eye condition or a requisition Diabetes, glaucoma, cataract, retinal disease, amblyopia, field defect, corneal disease, strabismus, recurrent uveitis, optic pathway disease, or a valid requisition from a doctor or NP. Written findings to the primary care provider. Limit: 1 per 12 months; nothing else billable that day.	\$53.60

- Patients 20 to 64 with no listed condition and no requisition: the routine exam and refraction-only visits are uninsured (GP28, A11).
- Unlike other doctors, an ophthalmologist can bill other services the same day as A237A or A239A (GP28).
- Over the limit? Don't swap in another visit code for the routine exam. A re-check after it is billed as a lesser assessment with diagnostic code 367 (GP28).
- A115A blocks every other service by you that day, including fields and OCT. If the patient needs testing or treatment, consider A233A or A234A instead (A11).
- Tonometry is part of the periodic exam; don't add G435A (GP28).

Optometrist referral

A253A	Optometrist-requested assessment Written request from the optometrist on the chart; written findings to the optometrist and the family doctor. Limit: 1 per 24 months.	\$86.25
A256A	Special optometrist-requested assessment Everything in A253A plus 50+ min face to face. Chart start and stop times. Limit: 1 per 24 months.	\$194.65
A241A	Optometrist request, neuro-ophthalmic disorder Neuro-ophthalmology fellowship; 4 of the 7 exam elements. Limit: 1 per 24 months.	\$155.45
A931A	Optometrist request, uveitis or ocular inflammation Uveitis fellowship; dilated fundus exam plus review of labs and imaging. Limit: 1 per 24 months.	\$157.00

- Optometrist referrals use A253A, not A235A: the optometrist's written request must be on the chart or it's paid as a lesser fee (A159).
- Send your findings in writing to both the optometrist and the primary care provider, or it's paid as a lesser fee (A159).
- 50+ minutes face to face: A256A pays \$194.65 instead of \$86.25 (A159).
- A253A and A256A can be done by video, never by phone (A67, Appendix J).
- Paid on top of the assessment: orthoptic assessment A230A (\$26.20, A156A), an MTO driving report K035A (\$36.25, A59) and the northern travel grant form K036A (\$10.25, A60).

Injection, laser or minor procedure

- Wet AMD injections: E186A left eye, E187A right eye, \$90 each, each up to 12 per 12 months. Any other intravitreal drug (diabetic macular edema, vein occlusion) is E149A (Y6).
- More than 8 AMD injections a year should have documented disease instability (Y7).
- The visit where you examine, review the OCT and decide to treat is billable with the injection or laser (SP2). A pre-booked treatment with no new decision includes the pre-op check (SP1).
- OCT while actively treating with injections or laser: G821A (\$35) counts toward the 4-a-year OCT limit; once it's reached, G822A (\$25) up to 8 more (J93).
- Z procedures (foreign body, chalazion, ulcer cautery) booked at an earlier visit: only a partial assessment (A234A) is payable before them (SP4).

Called to ED

A235A	Consultation Referred by the ED doctor.	\$86.25
A233A	Specific assessment Patient you know, full eye exam.	\$60.50
A234A	Partial assessment Brief exam and advice.	\$31.95

- Bill the A-prefix consult or assessment plus the K special visit premiums; chart the time of the visit (GP65, GP69).
- Non-elective surgery after a call-in, 17:00–07:00 or weekend: tick E409A (+50%) or E410A (+75% nights) on the procedure fee (SP2, GP104).
- In hospital, drop E542A from procedure codes: the tray fee is paid only outside hospital (Y10).

In-patient consult

C235A	Consultation, routine Non-emergency in-patient consult.	\$85.95
A235A	Consultation, called in Non-elective special visit to a ward patient; add the C special visit premiums.	\$86.25
C236A	Repeat consultation Same problem, new request, after another doctor cared for the patient in between (GP19).	\$48.00
C231A	Neuro-ophthalmology consultation Same conditions as A231A: neuro-ophthalmology fellowship, neuro-ophthalmic disorder, 4 of the 7 exam elements (A154, A162).	\$155.45
C930A	Uveitis consultation Same conditions as A930A: uveitis fellowship; dilated fundus exam plus review of labs and imaging (A154, A162).	\$157.00
C233A	Specific assessment	\$60.50
C234A	Specific re-assessment	\$30.75
C250A	Retinopathy of prematurity assessment Same conditions as A250A: 9 months or younger, or 10 months to 16 years with stage 3+ ROP. No other assessment by you that day (A156, A162).	\$125.80

- Neuro-ophthalmology and uveitis consults pay about \$155 in hospital too: C231A and C930A carry the same conditions as A231A and A930A (A162).
- Surgeons can't bill the admission assessment unless it is the visit where the decision to operate was made (SP2).
- Following the patient afterwards? Pick "Hospital rounds" for subsequent, MRP and concurrent care visits.

Hospital rounds

C232A	Subsequent visit, weeks 1 to 5 1 per day. Weeks 6 to 13: C237A (max 3 per week); after week 13: C239A (max 6 per month) (GP43).	\$31.00
C238A	Concurrent care Another doctor stays MRP and asked you to keep directing eye care. Limit: 4 in week 1, then 2 a week.	\$31.00
C122A	You're the MRP: day after admission Once per admission; not the same day as C124A or C126A (GP44).	\$71.80
C123A	You're the MRP: second day after admission Once per admission (GP44).	\$71.80
C142A	You're the MRP: first visit after transfer out of the ICU Patient 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	You're the MRP: second visit after transfer out of the ICU Instead of C123A: one of C123A/C143A per admission. Not the same day as C124A or C126A (GP46).	\$71.80
C124A	You're the MRP: discharge day Stay of 48 h+; discharge summary within 48 h with reason, procedures, diagnosis, discharge meds (GP45).	\$71.80
C126A	You're the MRP: discharge day, medically complex Stay of 7+ consecutive days, 3+ diagnoses that lengthened it, 45+ minutes of your own time; otherwise paid as a lesser fee. One of C124A/C126A per admission (A13, GP45).	\$95.10

- Concurrent care is 4 claims in the first week and 2 a week after; extra claims pay \$0 (GP48).
- Admitted under you? The two days after admission and discharge day pay \$71.80 each instead of \$31.00 (GP44–GP45); C142A/C143A take the place of C122A/C123A after an ICU transfer (GP46).
- E083A adds 30% to your MRP subsequent visits, C121A, C122A–C126A, C142A, C143A and C982A, when the hospital doesn't pay you for in-patient care (GP47).
- After week 5, an acute intercurrent illness is C121A (\$40.05), outside the weekly visit limits (GP43). Palliative care visits as MRP: C982A \$40.05 (GP50).

E-assessment (eConsult)

U235A	Initial e-assessment First e-assessment by you for this patient and diagnosis; written opinion back. Limit: 1 per 12 months (2 if a new diagnosis).	\$48.05
U233A	Repeat e-assessment First one after your initial e-assessment or consult, same diagnosis.	\$45.40
U236A	Follow-up e-assessment Limited follow-up, same diagnosis. Limit: 1 a day, 4 per patient per 12 months.	\$30.35
U231A	Minor e-assessment Short answer to one specific question. Limit: 1 a day, 12 per patient per 12 months.	\$15.75

- Answer within 30 days and put the requester's billing number on the claim (GP35–GP36).
- Not payable when used to arrange a visit, procedure or transfer of care (GP35).
- Seeing the patient for the same diagnosis within 60 days of the request: that visit pays only A233A or A234A (GP35).

Also bill, if it's true

E409A	Non-elective surgery started 17:00–24:00 weekdays, or 07:00–24:00 weekend or holiday Adds 50% to the procedure fee(s). Non-elective, or an elective case pushed into that time by an emergency. Not for an ED physician on shift (E412A instead) (GP103–GP104, SP2).	+50%
E410A	Non-elective surgery started 00:00–07:00 Adds 75% to the procedure fee(s). Same conditions as E409A (GP104, SP2).	+75%
E420A	Trauma patient with ISS over 15 (over 12 under age 16) Adds 50% to the consult or visit and surgery, 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%
E423A	Manual cycloplegic refraction, age 15 or under Done by you, for strabismus or amblyopia needing glasses or contacts. Max 2 per 12 months.	\$25.00
E424A	Child 10 or under in active amblyopia treatment Occlusion, penalization, dichoptic or refractive therapy. Diagnostic code 368.	\$50.00
G818A	OCT, retinal disease Macular blood or exudate, folds, hole, unexplained vision loss, or suspected CNV, fluid or CME. Up to 4 OCTs a year (G818A, G820A, G821A combined); 18+.	\$35.00
G820A	OCT, glaucoma Suspicious nerve or field, raised pressure, or family history. Max 2 a year; 18+.	\$35.00
G821A	OCT, active laser or injection treatment Counts toward the 4-a-year limit; 18+.	\$35.00
G822A	OCT, injection or laser for neovascular disease, after the limit Wet AMD, diabetic macular edema or vein occlusion, once the 4 a year are used. Max 8 per 12 months.	\$25.00
G823A	OCT, patient under 18 Retinal disease, glaucoma or low vision with developmental delay. Max 12 per 12 months.	\$35.00
G858A + G432A	Static visual fields Pathology present or suspected; 50+ points per eye, fixation monitored, permanent record.	\$42.40
G857A + G436A	Kinetic visual fields With permanent record.	\$19.60
G853A + G425A	Fluorescein angiography Both eyes: add 50% of the listed fee.	\$69.90
A230A	Orthoptic assessment, done by you All cardinal gazes, suppression, cyclodeviation, retinal correspondence; results charted.	\$26.20
G814A	Orthoptic exam by your certified orthoptist You interpret it.	\$25.00
G435A	Tonometry Only with a partial assessment; included in consults, specific assessments and periodic exams.	\$5.10
G813A	Corneal pachymetry Glaucoma risk only. Once per lifetime.	\$5.10
G810A	Corneal topography Irregular astigmatism from scarring, keratoconus and listed ectasias, post-graft or pterygium, cross-linking. Keratometry G811A same price.	\$4.80
G812A	Specular microscopy before intraocular surgery Fuchs, pseudophakic keratopathy or other endothelial risk.	\$4.80
G850A + G438A	Detailed colour vision testing Pathology present or suspected; a screening test plus 2 detailed tests. Not routine screening.	\$45.80
E083A	You're the most responsible physician Adds 30% to MRP subsequent visits, C121A, C122A–C126A, C142A, C143A and C982A, if the hospital doesn't pay you for in-patient care (GP47).	+30%
K035A	Reported a medical condition to the MTO (driving) Vision or field below the driving standard, diplopia. More than one a year for the patient: submit with the manual review indicator. Paid on top of the visit (A59).	\$36.25
K036A	Northern health travel grant form Paid to the specialist as well as the referring doctor (A60).	\$10.25

K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a referral, transfer, visit or test, or mainly to discuss results. Max 1 per patient per day. Paid on top of the visit (A42–A43).	\$37.05
K738A	Sent an e-consult to another doctor Through a secure e-consult service; paid once the other doctor answers within 30 days. Max 1 a day and 6 per patient per 12 months. Paid on top of the visit (A48–A49).	\$16.45
A234A	Also did a partial assessment Before a Z procedure booked at an earlier visit, a partial assessment is the only visit fee allowed (SP4).	\$31.95

Did a procedure?

E186A	Intravitreal injection, wet AMD, left eye Max 12 per 12 months.	\$90.00
E187A	Intravitreal injection, wet AMD, right eye Max 12 per 12 months.	\$90.00
E149A	Intravitreal injection, other than AMD Diabetic macular edema, vein occlusion, endophthalmitis tap and inject.	\$90.00
E175A	Therapeutic paracentesis with the injection Not through the same site as the injection.	\$20.00
E139A	YAG capsulotomy Not when done to facilitate another operation.	\$161.75
E131A	Laser iridotomy	\$161.75
E134A	Laser angle surgery (SLT, ALT) or cyclophotocoagulation	\$205.55
E154A	Retinal laser photocoagulation, one eye PRP, focal or barrier laser.	\$182.75
G421A	Subconjunctival or sub-Tenon's injection Both eyes: add 50%.	\$27.70
Z847A	Embedded corneal foreign body, one	\$33.00
Z848A	Embedded corneal foreign bodies, two Three or more: Z845A (IC).	\$45.00
Z871A	Corneal ulcer cautery or debridement Includes epithelial debridement, corneal biopsy or puncture.	\$26.60
Z874A + E542A	Chalazion excision, one or more Insured only for acute inflammation, induced astigmatism, field defect or suspected malignancy.	\$82.65
Z854A	Eyelid abscess drainage	\$60.00
Z861A	Conjunctival biopsy	\$26.60
Z857A	Lash epilation by hyfrecator, electrolysis or cryo	\$115.80
Z860A	Zeigler punctures for entropion or ectropion	\$26.60
Z901A	Nasolacrimal irrigation, per eye	\$27.00
Z902A	Probing of the tear duct, local, one side	\$27.00
G871A	Botox for blepharospasm One or both sides. One treatment per condition per 10 weeks.	\$120.00
E202A	Corneal cross-linking Progressive keratoconus, post-refractive ectasia, pellucid, keratoconus after graft.	\$200.00
G460A	Photodynamic therapy, one eye Both eyes G461A (\$500). Strict CNV criteria, retinal photos on file.	\$330.00
E140A	Cataract extraction with IOL (booked surgery) Retrobulbar block by you included.	\$397.75
E115A + E110A	MIGS combined with cataract surgery E115A alone \$350.	\$621.50

Can I bill these together?

Code	With	Together ?	Why
E078A	A233A, A234A, A250A, A251A, A252A, A254A	No	E078A is only paid to the specialties listed in GP25; Ophthalmology (23) isn't one of them (GP25).
G435A	A235A, A236A, A935A, A231A, A930A, A233A, A253A, A256A, A241A, A931A	No	Tonometry is included in an eye consultation or specific assessment (J89).
G435A	A237A, A239A	No	Tonometry is part of the periodic oculo-visual assessment (GP28).
G435A	A234A	Yes	Tonometry may be billed with a partial assessment (J89).
A115A	G818A, G820A, G821A, G822A, G823A, G858A, G432A, G857A, G436A, G853A, G425A, G435A, G813A, G810A, G811A, A230A, G814A, E423A, E424A, Z847A, Z874A, E186A, E187A, E149A, K035A, K036A, K730A, K738A	No	Any other service by you to the same patient the same day as a major eye examination pays \$0 (A11).
A250A,A251A,A252A, A254A	A235A, A236A, A935A, A231A, A930A, A233A, A234A, A253A, A256A, A241A, A931A, A237A, A239A, A115A	No	No other consultation or assessment by you is payable the same day as A250A, A251A, A252A or A254A (A156, A157, A161).
G818A,G820A,G821A,G822A	G818A, G820A, G821A, G822A, G823A	No	Only one OCT (G818A, G820A, G821A, G822A or G823A) per patient per day (J94).
G823A	G823A	No	Only one OCT per patient per day (J94).
E423A,E424A	A235A, A236A, A935A, A231A, A930A, A253A, A256A, A237A, A239A	No	E423A and E424A are add-ons to A233A or A234A only (A155).
E423A,E424A	A233A, A234A	Yes	Listed add-ons to A233A or A234A (A155).
A230A	G814A	Sometimes	A230A is the orthoptic assessment you do yourself; G814A is the exam by your certified orthoptist that you interpret. Bill the one that matches who did the testing (A156, J94).
A237A,A239A	G818A, G820A, G858A, G432A, G857A, G436A, G853A, G425A, G813A, E186A, E187A, E139A, Z847A	Yes	The same-day restriction after a periodic eye exam doesn't apply to ophthalmologists (GP28).
E186A,E187A,E149A	Z851A, Z844A	No	Z851A and Z844A aren't payable the same day as an intravitreal injection; bill E175A for paracentesis with the injection (Y2).
E175A	Z851A	No	Z851A isn't payable the same day as E175A (Y2).
E175A	E186A, E187A, E149A	Sometimes	E175A is payable with the injection unless the paracentesis goes through the same site (Y6).
E186A,E187A,E149A, E139A,E131A,E134A, E154A,E202A	A233A, A234A, A235A, A935A, A253A, A256A	Sometimes	Paid when this is the visit where you examined and decided to treat (the major pre-op visit, SP2). A pre-booked treatment with no new decision includes the pre-op check (SP1).

Code	With	Together ?	Why
Z847A,Z848A,Z871A,Z874A,Z854A,Z861A,Z857A,Z860A,Z901A,Z902A	A233A, A235A, A935A, A253A, A256A	Sometimes	Paid when you decided on the procedure at this visit or it's for an unrelated problem. If you decided at an earlier visit in the last 12 months, only A234A is payable before the Z procedure (SP4).
Z847A,Z848A,Z871A,Z874A,Z854A,Z861A,Z857A,Z860A,Z901A,Z902A	A234A	Yes	A partial assessment is payable before a Z procedure, even one booked earlier (SP4).
E139A	E140A	No	E139A isn't payable when done to facilitate the main operation, such as lens extraction (Y5).
E234A	E140A, E141A	No	Canthotomy is not claimed with cataract surgery (Y11).
E140A	A235A, A935A	Sometimes	A pre-op consultation before cataract surgery under local or IV sedation is paid only when the chart shows it was medically necessary (GP18).
G818A,G820A,G821A	E140A	No	OCT done in whole or in part to prepare for cataract surgery isn't payable (J93).
G460A	G461A	No	Unilateral PDT pays \$0 the same day as bilateral PDT; max one PDT per patient per day (J96).
E202A	E117A	No	Cross-linking isn't payable the same day as E117A (Y2).
C122A,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).
E083A	C238A	No	E083A is for the MRP; concurrent care means another doctor is the MRP (GP47–GP48).
C250A	C235A, C236A, C231A, C930A, C233A, C234A	No	No other assessment or consultation by you the same day as an ROP assessment (A156, A162).
E950A	E156A, E157A	No	E950A isn't paid with E156A or E157A (Y4).
U235A	A235A, A935A	Sometimes	A consult for the same diagnosis within 60 days of the e-assessment request is paid only as A233A or A234A (GP35).
G460A,G461A	A233A, A234A, A235A, A935A, A236A, A253A, A256A	Yes	Assessments and angiography are paid on top of PDT; retinal photography is part of the assessment, not billed separately (J96).
A230A	A235A, A935A, A236A, A231A, A930A, A233A, A234A, A253A, A256A, A241A, A931A	Yes	An orthoptic assessment is paid in addition to an ophthalmology consultation or visit, when you do and interpret all the tests yourself (A156).
A230A	A237A, A239A	Yes	An orthoptic assessment is paid in addition to an ophthalmology visit (A156), and the same-day bar after a periodic eye exam doesn't apply to ophthalmologists (GP28).

Code	With	Together ?	Why
K730A,K738A	A235A, A935A, A236A, A231A, A930A, A233A, A234A, A253A, A256A, A241A, A931A, A251A, A252A, A254A, A237A, A239A	Yes	The referring doctor's phone consult or e-consult is paid in addition to visits the same day. Not to arrange a referral, visit or test, or mainly to discuss results (A42, A48–A49).
K035A,K036A	A235A, A935A, A236A, A231A, A930A, A233A, A234A, A253A, A256A, A241A, A931A, A251A, A252A, A254A, A237A, A239A	Yes	The MTO report and the northern travel grant form have no same-day rule; paid on top of the visit (A59–A60).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (pages in brackets). Technical + professional components are shown together for office testing; in hospital the technical part may pay less (GP11). The tray fee E542A is included in procedure totals; drop it in hospital. Age premiums on A233A, A234A, consultations and surgery for children under 16 (GP64) and special visit premiums are applied by OHIP and aren't all shown here.

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