

Orthopaedic Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 06 · Follow-up or fracture clinic · Fracture or dislocation · Injection or aspiration only · Updated October 2026
Interactive version: <https://verismo-apex.com/resources/ohip-billing-cheatsheet/orthopaedic-surgery>

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

Office consultation

A065A	Consultation Written referral from a physician or NP in the chart; report back to them (GP16).	\$89.80
A935A	Long consultation, 50+ minutes Special surgical consultation: 50+ minutes face to face, not counting procedures or chart and imaging review. Chart start and stop times (GP19–GP20).	\$194.65
A066A	Repeat consultation Same problem again after another doctor treated it in between. Needs a new written referral (GP19).	\$55.35
A063A	No written referral Paid as a specific assessment: full history of the complaint and detailed exam of the area (GP16, GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$45.55

- A935A pays \$194.65, more than double A065A, when you spend 50+ minutes with the patient. Time spent on procedures and reviewing imaging doesn't count (GP19–GP20).
- The consult is paid on top of a fracture, dislocation or surgical fee: it is the major pre-op visit, whenever it happened (N1, SP2).
- One consult per patient per diagnosis every 2 years; a clearly unrelated diagnosis allows 1 per 12 months. Extra ones are paid as an assessment (GP17).
- A referral written after you saw the patient doesn't count: bill the visit instead (GP16).
- Booking a Z-coded procedure (cast change, minor surgery) for a later day? On that day only a partial assessment (A064A) is paid with it (SP4).

Follow-up or fracture clinic

A064A	Follow-up check Partial assessment: history of the complaint, the exam needed, advice (GP25).	\$25.95
A063A	Full work-up of a new or different problem Specific assessment: full history of the complaint and detailed exam of the area (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$45.55

- Cast change after the first 2 weeks: add the cast code (Z203A arm, Z213A below knee, Z211A whole leg) from the procedure list. Casts in the first 2 weeks after a fracture or dislocation fee are included (N7).
- A planned cast change or other Z procedure allows only A064A with it that day, not A063A (SP4).
- Took over after-care of a fracture someone else treated? Bill your visits; the first doctor bills 75% of the fracture fee (80% after open reduction) (N2).
- Hardware out under local, 30+ days after it went in: R268A (\$54.85). Wires and pins used for traction or external fixation come out free unless a general anaesthetic is needed (N1, N3).
- Specific assessments are capped at 1 per patient per 12 months (2 for a clearly different diagnosis); extras are paid as A064A (GP23).
- E078A (chronic disease premium) isn't payable to orthopaedic surgery (06): 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.

Fracture or dislocation

A065A	Referred: consultation Paid on top of the fracture or dislocation fee (N1).	\$89.80
A935A	Referred: 50+ minute consultation Start and stop times charted; procedure time doesn't count (GP19–GP20).	\$194.65
A063A	Not referred: specific assessment Full history of the injury and detailed exam (GP23).	\$45.55

- "No reduction" fees need a custom-moulded rigid cast or splint you applied. A prefabricated or simple metal splint is a visit fee only (N1).
- Clavicle and rib fractures without reduction have no fracture fee: bill the visit (N26).
- Several fractures at once: the main one at 100%, each other one at 85% (N1). Repeat reduction of the same fracture: the final one at 100%, your earlier ones at 85% (N2).
- The ED doctor's emergency splint is billed as their visit plus a cast (N2), so the fracture fee is yours when you give the definitive treatment.
- Handing after-care to another doctor: claim 75% of the fee (80% after open reduction). A failed reduction under general anaesthetic sent elsewhere: 75% (N2).

Injection or aspiration only

- Aspirating any joint other than the knee (shoulder, elbow, wrist, hip, ankle) pays G328A \$39.80 instead of G370A \$20.25. G328A isn't payable for an injection alone (J53).
- Add E542A (\$12.65) to the first G370A or G328A done in your office; not in hospital and not on G371A or G329A (J53).
- Only one injection code per joint or bursa. The olecranon bursa is always G370A/G371A (J53).
- Hyaluronic acid (viscosupplement) injections are uninsured (J53). Missed it blind and redid it under image guidance: add E446A (\$30) to G370A or G371A (J53).
- Injection was the only reason for the visit: add G700A (\$8.80), once per visit, not in hospital (J3).

Called to the ED

A065A	Consultation A request on the hospital's common record counts as the written referral (GP16).	\$89.80
A935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
A063A	Specific assessment Your own patient, or no consult request.	\$45.55

- Use the A-codes here, not C-codes, with the ED special visit premiums. Chart the time you saw the patient (GP69).
- Reduction or other non-elective surgery started 17:00–24:00 weekdays or any time on a weekend or holiday: E409A adds 50% to the procedure fee; nights 00–07: E410A adds 75% (SP2, GP104).
- Already at the hospital? Evenings, weekends and nights still earn the first person seen premium without travel (GP66).
- Weekday daytime: the first person premium needs either travel or office patients you delayed or cancelled (GP65–GP66).

Urgent call to a ward patient

A065A	Consultation Another physician's in-patient, non-elective request.	\$89.80
A935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
A063A	Specific assessment Another physician's patient seen urgently.	\$45.55

- Non-elective calls to a ward use A-codes with the in-patient premiums. Routine ward consults are C065A with no premium (GP43, GP65).
- No premiums for patients seen on rounds or for elective admission assessments (GP65).
- The travel premium needs a trip from another location; not between buildings on the same hospital campus (GP66).

Hospital rounds

C062A	Routine visit, weeks 1 to 5 1 per day. Weeks 6 to 13: C067A (max 3 per week); after week 13: C069A (max 6 per month) (GP43).	\$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
C068A	Concurrent care Another doctor is the MRP and asked you to keep following (GP48).	\$31.00

- As MRP, the two days after admission and discharge day pay \$71.80 each instead of \$31.00 (GP44–GP45). Came from the ICU? C142A/C143A take the place of C122A/C123A (GP46).
- A long, complex stay (7+ days, 3+ contributing diagnoses, 45+ min on discharge day) pays C126A \$95.10 instead of C124A \$71.80 (A13).
- 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).
- Visit limits count from admission, or from the referral date if the patient was referred to you in hospital (SP2). The surgeon can't bill the admission assessment unless it was the decision-to-operate visit (SP2).
- Pre-booked team meeting about your in-patient (you or another physician is MRP, plus 2 others, 10+ min): K121A \$37.05 per 10-minute unit, on top of that day's visit as long as the visit wasn't during the meeting (A31–A33).

In-patient consult (non-urgent)

C065A	Consultation Written request in the hospital chart (GP16).	\$89.80
C935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
C066A	Repeat consultation Same problem after another doctor treated it in between (GP19).	\$55.35
C063A	Specific assessment Full history of the complaint and detailed exam (GP23).	\$45.55
C064A	Specific re-assessment 2 per 12 months, except admissions (GP23).	\$27.30

- Called urgently instead of on rounds? Pick "Urgent call to a ward patient": the A-code plus premiums pays more.
- The consult that leads to surgery is the major pre-op visit and is paid on top of the surgery (SP2).

Phone or video

A065A + K300A	Consultation by video Consults are video only, on an Ontario Health verified platform (A67–A68, Appendix J).	\$89.80
A064A + K300A	Follow-up by video Full fee.	\$25.95
A064A + K301A	Follow-up by phone Phone pays 85% of the in-person fee (A70).	\$25.95
A063A + K301A	Specific assessment by phone 85% of \$45.55 (A70).	\$45.55
A101A	Video, no relationship with the patient No in-person visit or video consult with you in the last 24 months (A66, A73).	\$20.00
A102A	Phone, no relationship with the patient	\$15.00
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit, fracture clinic or transfer, or mainly about results (A42–A43). Limit: 1 per patient per day.	\$47.75
K739A	e-Consult reply Opinion sent through a secure server within 30 days of the request (A48). Limit: 6 per patient per 12 months, 400 a year.	\$20.50

- The patient has to ask for the visit, or it follows up one they asked for. Check-in calls and normal results aren't billable (A68).
- If you find you need to examine the patient, only the in-person visit is paid (A67).
- A video consult counts as a relationship: follow-ups for 24 months can be by phone at 85% (A66).
- K731A and K739A aren't paid if you see the patient yourself (consult, assessment or visit) that day or the next (A43, A49).
- Write in the chart whether it was phone or video.

Long-term care

W065A	Consultation in LTC or chronic care Nursing home, home for the aged, chronic or convalescent hospital or bed. Written request in the chart (GP16, GP49).	\$89.80
W066A	Repeat consultation Same problem again after another doctor treated it in between (GP19).	\$55.35
W062A	Chronic care or convalescent hospital visit First 4 per patient per month; then W061A, up to 6 more a month (A165, GP49).	\$40.05
W063A	Nursing home or home for the aged visit First 2 per patient per month; then W068A, up to 3 more a month (A165, GP49).	\$40.05
W121A	Extra visit for an intercurrent illness Paid outside the monthly limits; not a special visit (GP49).	\$40.05
W124A	Discharge day, after 30+ days in the facility You're the MRP; discharge summary with follow-up; going home or elsewhere to another provider's care. Not for respite stays (A20, GP45).	\$71.80
A065A	Called in non-electively Called in for an urgent problem (special visit), or another physician's resident seen urgently: A-prefix code, with the LTC special visit premiums when eligible (GP49, GP66, GP73).	\$89.80

- Special visit premiums never apply to elective LTC visits, even though LTC is the resident's home (GP66).
- Already in the home and asked to see another doctor's resident urgently: bill A-prefix codes (no travel premium inside the same facility; first person seen premium only at eligible times). Your own residents stay on W codes (GP49, GP66).
- Palliative care visits as MRP: W982A in chronic care, W972A in a nursing home, \$40.05 each (GP50).

Also bill, if it's true

E542A	Tray fee: injection or aspiration done in your office Once, with the first G370A or G328A. Not in hospital (J53).	\$12.65
E584A	Plaster cast applied in your office Add to each cast code (Z198A–Z213A) applied outside a hospital or ICHSC (N7).	\$11.15
G700A	The injection was the only reason for the visit Once per visit, with G370A. Not in hospital, not with a consult or assessment (J3).	\$8.80
E409A	Non-elective procedure started 17:00–24:00 weekdays, or daytime or evening on a weekend or holiday Adds 50% of the ticked procedure fees. Fractures and dislocations count; not for ED physicians on shift (GP103–GP104).	+50%
E410A	Non-elective procedure started at night, 00:00–07:00 Adds 75% of the ticked procedure fees (GP104).	+75%
E420A	Major trauma: ISS over 15 (age 16+) or over 12 (under 16) Adds 50% to the consult and procedures done on the day of the trauma or within 24 h. ISS must be in the chart; same claim record. Not applied to special visit or after-hours premiums (GP109).	+50%
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%
K070A	Filled in the home care referral form You're most responsible for the patient's ongoing care (e.g. after surgery) and filled it in yourself or with your staff. Paid on top of the visit. Once per home care admission; not if they already get home care (A58–A59, GP9).	\$34.75
K121A	Pre-booked in-patient case conference, per 10-minute unit You and 2+ others (physicians, social workers or regulated health professionals), the MRP among the physicians; 10+ min about this patient; start/stop times, attendees and outcome charted. 4 per patient per 12 months, 8 units a day. Not if you're paid other than fee-for-service for it (A31–A33).	\$37.05

Did a procedure?

F027A	Distal radius fracture, no reduction (custom cast)	\$67.75
F028A	Distal radius fracture, closed reduction under local	\$109.45
F046A	Distal radius fracture, closed reduction under general	\$149.35
F018A	Scaphoid fracture, no reduction (rigid cast)	\$49.20
F008A	Metacarpal fracture(s), no reduction (rigid) One or more.	\$49.20
F009A	Metacarpal fracture, closed reduction Each additional: E504A \$22.20.	\$99.25
F004A	Finger phalanx fracture, no reduction (rigid)	\$49.20
F005A	Finger phalanx fracture, closed reduction Each additional: E558A \$22.25.	\$99.25
F053A	Proximal humerus (neck) fracture, no reduction	\$67.80
F034A	Olecranon fracture, no reduction (rigid)	\$126.25
F074A	Ankle fracture, no reduction (rigid)	\$67.75
F075A	Ankle fracture, closed reduction	\$144.80
F082A	Fibula fracture, no reduction (rigid)	\$67.75
F078A	Tibia fracture (± fibula), no reduction (rigid)	\$115.95
F062A	Metatarsal fracture(s), rigid immobilization Without a rigid cast: F061A \$49.20.	\$67.75
D015A	Shoulder dislocation, reduced without anaesthetic	\$49.20
D016A	Shoulder dislocation, reduced with anaesthetic	\$111.40
D012A	Pulled elbow, reduced	\$39.00
D001A	Finger dislocation, closed reduction Each additional: E576A \$10.25.	\$57.50
Z203A	Arm, forearm or wrist cast Not in the first 2 weeks after a fracture fee (N7).	\$24.10
Z213A	Below-knee cast or knee splint Not in the first 2 weeks after a fracture fee (N7).	\$24.10
Z211A	Whole leg cast Not in the first 2 weeks after a fracture fee (N7).	\$28.80
Z204A	Cast removal Not within 2 weeks of fracture or dislocation care (N7).	\$10.25
G370A	Joint, bursa, tendon sheath or ganglion injection or aspiration Add the E542A tray fee in your office.	\$20.25
G371A	Each additional joint, bursa, sheath or ganglion Up to 5.	\$19.90
G328A	Aspiration of a complex joint (not the knee) or bursa With or without injection. Add the E542A tray fee in your office.	\$39.80
G329A	Each additional complex joint or bursa aspirated Up to 2.	\$20.25
E446A	Image-guided joint injection after a failed blind attempt With G370A or G371A; imaging itself not billable (J53).	\$30.00
R268A	Hardware removal under local, 30+ days after insertion	\$54.85
N290A	Carpal tunnel release	\$197.15

Can I bill these together?

Code	With	Together ?	Why
Z222A,Z223A	A063A, A064A, A065A, A066A, A101A, A102A, A935A, C062A, C063A, C064A, C065A, C066A, C068A, C122A, C123A, C124A, C126A, C142A, C143A, C935A, K731A, K739A, W062A, W063A, W065A, W066A, W121A, W124A	No	Z222A/Z223A is paid at nil when you bill any other insured service for the patient that day (SP5 rule 22).
E078A	A063A, A064A	No	E078A is only paid to the specialties listed in GP25; Orthopaedic Surgery (06) isn't one of them (GP25).
A065A	A063A, A064A, A066A, A935A	No	Only one assessment is paid per visit (GP10).
A063A	A064A	No	Only one assessment is paid per visit (GP10).
A063A	Z203A, Z213A, Z211A, Z202A, Z199A, Z201A, Z204A, Z873A	Sometimes	Casts are Z codes (independent procedures). If you planned it at an earlier visit in the last 12 months, only a partial assessment (A064A) is paid before it that day (SP4).
A064A	Z203A, Z213A, Z211A, Z202A, Z199A, Z201A, Z204A	Yes	A partial assessment is the visit allowed with a planned Z procedure (SP4).
F027A,F028A,F046A,F018A,F008A,F009A,F004A,F005A,F053A,F034A,F074A,F075A,F082A,F078A,F062A,F061A,D015A,D016A	Z203A, Z213A, Z211A, Z202A, Z199A, Z201A, E584A	Sometimes	Casts applied in the first 2 weeks after a fracture or dislocation fee are included; later cast changes are billable (N7).

Code	With	Together ?	Why
D001A,D003A,D004A,D009A,D010A,D012A,D014A,D015A,D016A,D017A,D025A,D031A,D035A,D036A,D038A,D040A,D041A,D042A,F004A,F005A,F007A,F008A,F009A,F011A,F016A,F018A,F019A,F021A,F024A,F025A,F026A,F027A,F028A,F029A,F030A,F031A,F032A,F033A,F034A,F035A,F036A,F042A,F043A,F044A,F046A,F047A,F053A,F054A,F055A,F056A,F058A,F061A,F062A,F063A,F064A,F070A,F071A,F072A,F074A,F075A,F076A,F077A,F078A,F079A,F080A,F081A,F082A,F083A,F084A,F085A,F087A,F096A,F100A,F101A,F102A,F110A,F118A	A065A, A935A, A063A, C065A, C935A, C063A	Yes	For any fracture or dislocation (open, closed or no reduction), the consultation or assessment is the major pre-op visit and is paid in addition to the fracture or dislocation fee (N1).
A065A,A935A,C065A,C935A	Z199A, Z201A, Z202A, Z203A, Z204A, Z208A, Z211A, Z213A, Z873A	Yes	The consult is the visit where you decide on the cast, so it is the major pre-op visit and is paid on top (SP2, SP4). A cast in the first 2 weeks after your fracture or dislocation fee is included in that fee (N7).
K070A	A065A, A935A, A066A, A063A, A064A, C062A, C067A, C069A, C122A, C123A, C124A, C126A, C142A, C143A	Yes	The home care referral form is paid in addition to the assessment (A58). Once per home care admission, by the physician most responsible for ongoing care.

Code	With	Together ?	Why
K731A,K739A	A065A, A935A, A066A, A063A, A064A, C065A, C935A, C066A, C063A, C064A, C062A, C067A, C069A, C068A, C121A, C122A, C123A, C124A, C126A, C142A, C143A, W065A, W066A, W062A, W063A, W121A, W124A, A101A, A102A	No	Phone or e-consult advice isn't paid when you see the patient yourself (consultation, assessment or visit) the same day or the next day (A43, A49).
F028A	F046A	Sometimes	Repeat reduction of the same fracture: the final one at 100%, your earlier one at 85% (N2).
D015A	D016A	No	One reduction fee per dislocation: with or without anaesthetic (N27).
F074A	F075A	No	One fee per fracture: no reduction or closed reduction (N57).
G370A	G328A	Sometimes	Only one injection code per joint or bursa; both only if they were different joints (J53).
E446A	G328A, G329A	Sometimes	E446A only adds to G370A or G371A (J53).
G370A,G371A,G328A,G329A	N290A, R268A	Sometimes	Joint or bursa injection isn't paid with surgery on the same site (J53).
G700A	A065A, A935A, A066A, A063A, A064A, C065A, C063A	No	G700A is only for a visit where the procedure was the sole reason, and not in hospital (J3).
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).
F021A	F030A	No	F021A isn't paid with F030A for fractures of the same wrist (N22).
E063A	F030A	Sometimes	E063A (+50%) only when both dorsal and volar internal fixation are described for an AO/OTA Group C distal radius fracture (N22).
R687A	E494A, E495A	Sometimes	With a degenerative-knee scope only if Kellgren-Lawrence grade is under 3 on standing x-rays from the last 12 months and mechanical symptoms failed 6+ months of non-surgical care, unless the ministry approved it first (N45).
E495A	E496A	Sometimes	Not for the same meniscus: meniscectomy or repair, not both (N47).
E083A	C068A	No	E083A is for the MRP; concurrent care means another doctor is the MRP (GP47–GP48).
E409A	E410A	No	One after-hours rate per procedure, by its start time (GP104).
R268A	F027A, F028A, F074A, F075A	Sometimes	Removing pins or wires used for traction or external fixation is included unless a general anaesthetic is needed; internal fixation out after 30+ days is billable (N1).

Sources: Schedule of Benefits (July 1, 2026): General Preamble GP10–GP69 and GP104, Surgical Preamble SP1–SP4, Musculoskeletal N1–N59, Diagnostic and Therapeutic J3 and J53, Orthopaedic Surgery A164–A165, Practice in General A31–A33, A42–A49 and A58–A59, Virtual Care A66–A75. Surgeon fees shown; assistant and anaesthesia units are billed by those physicians. Totals leave out age premiums (OHIP adds 10–30% for children on consults and procedures) and the 85% rate on second fractures and repeat reductions (OHIP applies it on the remittance).

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