

Physical Medicine & Rehabilitation OHIP Billing Cheat Sheet 2026

OHIP specialty 31 · EMG / nerve conduction · Botox, blocks or injections · Rehab unit or department · Updated October 2026

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

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

Office consultation

A315A	Consultation Written referral from a physician or NP in the chart; report back to them (GP16).	\$220.80
A425A	Comprehensive consultation, 75+ minutes All elements of a consult plus 75+ minutes face to face, not counting procedures or chart and imaging review. Chart start and stop times or it pays a lesser fee (A175). Limit: 1 per 2 years by you.	\$342.25
A515A	Limited consultation A consult needing much less time than a full one (GP19).	\$106.60
A316A	Repeat consultation Same problem again after another doctor treated it in between. Needs a new written referral (GP19).	\$106.60
A313A	No written referral Paid as a medical specific assessment (GP16, GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$86.40

- Spent 75+ minutes with the patient? A425A pays \$342.25 instead of \$220.80. Write down start and stop times; EMG, injections and chart review don't count toward the 75 (A175).
- Referred only for an EMG/nerve conduction study? No consult is paid unless the referrer also asked for one (J103).
- Procedures (EMG, Botox, blocks, injections) are paid on top of the consult (J3).
- One consult per patient per diagnosis every 2 years; a clearly unrelated diagnosis allows 1 per 12 months. Extras are paid as an assessment (GP17).

Follow-up visit

A310A	Re-assessment Medical specific re-assessment: full relevant history and exam (GP23). Limit: 2 per 12 months.	\$75.90
A311A	Complex re-assessment, written report to the family doctor Complex, obscure or serious condition. Send your findings in writing to the primary care physician or it pays a lesser fee (GP24). Limit: 4 per 12 months.	\$82.75
A313A	Full assessment of a new problem Medical specific assessment: full history of the complaint and detailed exam (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$86.40
A511A	Complex physiatry: brain injury, stroke or spinal cord injury Ongoing management needing a physiatrist; includes a re-assessment. Not for TIA, uncomplicated concussion or ASIA E injury (A176–A177). Limit: 6 per 12 months.	\$114.80
A510A	Complex neuromuscular: neuropathy, myopathy, NMJ or motor neurone disease Ongoing management, not your first evaluation. Not for carpal tunnel, Bell's palsy or uncomplicated diabetic neuropathy (A176). Limit: 6 per 12 months.	\$104.85
A318A	Brief check Partial assessment: history of the complaint, the exam needed, advice (GP25).	\$44.45

- Stroke, brain injury or spinal cord injury patient? A511A pays \$114.80, more than any re-assessment (A176).
- Chronic disease from the GP26 list (e.g. MS 340, Parkinson's 332, cerebral palsy 343, RA 714, ankylosing spondylitis 720, diabetes 250): E078A adds 50%. A313A + E078A = \$129.60. Office or out-patient clinic only (GP25–GP26).
- E078A can't go with A510A or A511A (A176).
- A311A pays more than A310A when you write to the family doctor; A313A and A311A together are capped at 4 per patient per 12 months (GP23–GP24).
- Over the limit? Assessments past their cap are paid as a lesser fee, so step down to A318A rather than lose the visit (GP23).

EMG / nerve conduction

G455A + G456A	Schedule A: complete study, your equipment 2+ nerves presumed involved plus needle EMG of the right muscles (J103).	\$151.80
G466A + G457A	Schedule B: limited study, your equipment One nerve and/or limited needle EMG (J103).	\$95.80
G471A + G473A	Schedule C: complex study, your equipment 60+ minutes of your direct involvement and 10+ studies; start and stop times charted (J104).	\$306.80
G456A	Schedule A, interpretation only Hospital or someone else owns the equipment.	\$120.00
G457A	Schedule B, interpretation only	\$74.40
G473A	Schedule C, interpretation only 60+ minutes, start and stop times (J104).	\$275.00

- Own the machine and do it yourself or supervise your technician: bill both the technical and professional parts (J103).
- Direct referral for the study only: no consult, unless the referrer asked for one too (J103).
- Needle EMG only: surface EMG isn't payable (J103).
- Schedule C pays \$275 professional for complex cases (demyelinating neuropathy, plexopathy, MND, NMJ disorders). Not with G456A or G457A the same day (J104).
- In hospital the technical part is paid at 86.10%, and never for in-patients (GP11).

Botox, blocks or injections

- Botox for spasticity or dystonia: G875A for the first injection, G876A for each extra (up to 11), plus G877A (one injection) or G878A (two or more) if you used EMG or ultrasound to find the site. Disposable EMG needle in your office: E543A \$30.60 once a day (J51).
- Botox: one treatment per condition every 10 weeks; more often needs manual review (J52).
- Phenol in the same muscle the same day as Botox pays \$0 (J105).
- A block you give as the anaesthetic for your own procedure isn't paid. Max 8 nerve blocks per patient per day; image guidance isn't billable (J79).
- Facet and medial branch blocks are diagnostic only, max 6 per 12 months, with final-needle images in the chart (J74–J75).

In-patient consult

C315A	Consultation Written request in the hospital chart (GP16).	\$233.65
C425A	Comprehensive consultation, 75+ minutes Start and stop times charted (A175, A178). Limit: 1 per 2 years by you.	\$342.25
C515A	Limited consultation	\$106.60
C316A	Repeat consultation Same problem after another doctor treated it in between (GP19).	\$106.60
C313A	Medical specific assessment	\$86.40
C511A	Complex physiatry assessment Brain injury, stroke or spinal cord injury; ongoing management (A178).	\$114.80

- The in-patient consult (C315A) pays \$12.85 more than the office one.
- Called urgently instead of on rounds? Pick "Urgent ward call": the A-code plus premiums.
- E078A isn't payable for in-patients (GP25).

Hospital rounds

C312A	Routine visit, weeks 1 to 5 1 per day (GP43).	\$40.05
C311A	Complex re-assessment, report to the family doctor Complex, obscure or serious condition (GP24). Limit: 4 per 12 months.	\$82.75
C122A	You're the MRP: day after admission Once per admission; not the same day as C124A (GP44).	\$71.80
C123A	You're the MRP: second day after admission Once per admission (GP44).	\$71.80
C124A	You're the MRP: discharge day Stay of 48 h+; discharge summary within 48 h (GP45).	\$71.80
C318A	Concurrent care Another doctor is the MRP and asked you to keep following (GP48).	\$40.05
C142A	You're the MRP: 1st visit after transfer out of ICU Patient was getting critical, ventilatory or comprehensive care there, not just monitoring. Instead of C122A; not if you gave the critical care (GP46).	\$71.80
C143A	You're the MRP: 2nd visit after transfer out of ICU Instead of C123A; same conditions as C142A (GP46).	\$71.80

- As MRP, the two days after admission and discharge day pay \$71.80 each instead of \$40.05 (GP44–GP45).
- MRP subsequent visits: E083A adds 30%, or E084A adds 45% on Saturdays, Sundays and holidays (physiatry qualifies). Not if the hospital pays you for in-patient care (GP47).
- Patient came to you from the ICU? C142A/C143A pay \$71.80 for your first two visits; one of C122A/C142A and one of C123A/C143A per admission (GP46).
- Weeks 6 to 13: C317A, max 3 a week; after week 13: C319A, max 6 a month. Acute intercurrent illness after week 5: C121A, outside those limits (A178, GP43). Palliative care as MRP: C982A (GP50).

Rehab unit or department

H312A	Rehab unit team management, weeks 1 to 12 Per visit (A180).	\$50.15
H317A	Rehab unit, weeks 13 to 26 Max 3 per week (A180).	\$50.15
H319A	Rehab unit, week 27 onwards Max 6 per month (A180).	\$50.15
K313A	Physiatric management of therapy, nothing else billed today Patient you've consulted or assessed, on a day they get rehab therapy. No other service by you that day (A180).	\$8.10
H313A	Rehabilitation counselling Booked counselling with the patient or family, 20+ min per unit; start and stop times charted. Counselling day: no H312A visit or procedure by you, only the GP58 list (A180, GP58, GP60).	\$84.20

- Rehab unit visits pay \$50.15 against \$40.05 for acute-care C312A.
- If care started in acute care, the weekly and monthly limits carry over: you can't max out C312A/C317A/C319A and then restart at H312A (A180).
- Rehabilitation counselling H313A pays \$84.20 per unit with one or more people; chart start and stop times. It's counselling, so no H312A visit or procedure that day (A180, GP58).
- K313A is not an administrative fee for running the department (A180).

Long-term or chronic care

W515A	Consultation Chronic care or convalescent hospital, nursing home or home for the aged; written request (A179, GP16).	\$233.65
W512A	Admission assessment, type 1 General assessment on admission. Lesser fee if you did a consult or general (re-)assessment before admission (GP49).	\$69.35
W514A	Admission assessment, type 2 First visit after admission when you already did a consult or general (re-)assessment before it (GP49).	\$20.60
W517A	Admission assessment, type 3 General re-assessment on re-admission after 3+ days in another institution (GP49).	\$30.70
W312A	Chronic care hospital visit, first 4 this month Routine visit (A179, GP49).	\$40.05
W311A	Chronic care hospital visit, 5th onwards After the first 4 this month (A179). Limit: 6 per month.	\$40.05
W313A	Nursing home visit, first 2 this month Nursing home or home for the aged (A179, GP49).	\$40.05
W318A	Nursing home visit, 3rd onwards After the first 2 this month (A179). Limit: 3 per month.	\$40.05

- Stroke, brain injury or spinal cord injury patient? W511A (\$114.80); neuropathy, myopathy, neuromuscular junction or motor neurone disease: W510A (\$104.85). Instead of a \$40.05 visit, same conditions as A511A/A510A: 6 per 12 months, no E078A (A176, A179).
- Acute intercurrent illness: W121A (\$40.05), paid outside the monthly limits. If it needs a special visit, bill the A code with premiums instead (GP49).
- Periodic health visit W419A pays \$65.05; the nursing-home general re-assessment W314A (\$20.60) only 6 months after it (A179).
- Discharge day after a 30+ day stay, care handed to another provider: W124A pays \$71.80; not for respite admissions (A20). Palliative visits: W982A (chronic care) or W972A (nursing home) (GP50).
- Already in the building and asked to see another doctor's patient urgently? Bill the A code, not W (GP49).

Urgent ward call

A315A	Consultation Another physician's in-patient, non-elective request.	\$220.80
A515A	Limited consultation	\$106.60
A313A	Medical specific assessment Another physician's patient seen urgently.	\$86.40

- Non-elective calls to a ward use A-codes with the in-patient premiums; routine ward consults are C315A with no premium (GP43, GP65).
- No premiums on rounds or for elective admissions (GP65). Chart the time of the visit (GP69).
- Already at the hospital? Evenings, weekends and nights still earn the first person seen premium without travel (GP66).

Phone or video

A315A + K300A	Consultation by video Consults are video only, on an Ontario Health verified platform (A67–A68, Appendix J).	\$220.80
A310A + K300A	Re-assessment by video Full fee.	\$75.90
A311A + K301A	Complex re-assessment by phone Phone pays 85% of \$82.75 (A70).	\$82.75
A511A + K301A	Complex physiatry by phone 85% of \$114.80 (A70).	\$114.80
A318A + K301A	Brief check by phone 85% of \$44.45 (A70).	\$44.45
A102A	Phone, no relationship with the patient No in-person visit or video consult with you in the last 24 months (A66, A73). Video: A101A \$20.	\$15.00

- E078A (+50%) still applies to virtual re-assessments and partial assessments (A74).
- 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).
- A video consult counts as a relationship: follow-ups for 24 months can be by phone at 85% (A66).
- Write in the chart whether it was phone or video.

Also bill, if it's true

E078A	Established chronic disease from the OHIP list Use the listed diagnostic code on the claim (e.g. 340 MS, 332 Parkinson's, 343 CP, 714 RA, 720 AS, 250 diabetes). Office or out-patient clinic, not ED, in-patient or LTC (GP25–GP26).	+50%
E542A	Tray fee: joint or bursa injection done in your office Once, with the first G370A or G328A. Not in hospital (J53).	\$12.65
G700A	A joint injection was the only reason for the visit With G370A. Once per visit, not in hospital, not with an assessment (J3).	\$8.80
E083A	You're the MRP, weekday Adds 30% to MRP subsequent visits, if the hospital doesn't pay you for in-patient care (GP47).	+30%
E084A	You're the MRP, Saturday, Sunday or holiday Adds 45% instead of E083A (GP47).	+45%
H313A	Rehabilitation counselling Per half-hour unit or major part, one or more people; start and stop times charted (A180, GP7).	\$84.20
K035A	Reported a medical condition to the MTO Mandatory driver report (e.g. after stroke, brain or spinal cord injury). Paid on top of the visit; more than 1 per 12 months for the same patient goes to manual review (A59).	\$36.25
K036A	Filled in the Northern Health Travel Grant form Specialist's part of the form; payable to the referring doctor and the specialist (A60).	\$10.25
K038A	Long-term care health assessment form Completed and sent to Ontario Health atHome for a patient applying to long-term care (A60).	\$46.35
K070A	Home care referral form to Ontario Health atHome You're the MRP giving ongoing care. Paid on top of the assessment. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K002A	Interview with relatives or substitute decision-maker Per half-hour unit (20, 46, 76 min...). Separately booked, 20+ minutes, when the patient can't give or receive the information (e.g. brain injury, aphasia); not just history-taking for the visit or only for consent (A28, GP61).	\$80.00
K730A	Phoned another specialist for advice about this patient You're the referring doctor; 10+ minutes, start and stop times charted. Not to arrange a referral, a transfer or to discuss test results. Paid on top of today's visit; 1 per patient per day (A42–A44).	\$37.05
K738A	Sent an e-consult to another specialist You're the referring doctor; secure e-consult, answered within 30 days. Paid on top of today's visit; 1 a day, 6 per patient per 12 months (A48–A49).	\$16.45
K121A	In-patient case conference Per 10-minute unit (10, 16, 26, 36 min...). Acute care or rehabilitation hospital in-patient. Pre-scheduled, with the MRP plus 2+ other physicians or regulated professionals; chart start/stop, participants and outcome. Paid with today's visit, as long as the visit was done outside the conference. Max 4 per patient per 12 months, 8 units a day (A31–A33).	\$37.05
K707A	Chronic pain out-patient case conference Per 10-minute unit. You're treating the chronic pain (6+ months); pre-scheduled, with 2+ other physicians or regulated professionals. Paid with today's visit if the visit was done outside the conference. No phone consultation (K730A) the same day; max 4 per patient per 12 months (A31–A32, A37).	\$37.05

Did a procedure?

G455A + G456A	EMG/NCS Schedule A, your equipment Complete study (J103).	\$151.80
G466A + G457A	EMG/NCS Schedule B, your equipment Limited study (J103).	\$95.80
G471A + G473A	EMG/NCS Schedule C, your equipment 60+ min, 10+ studies, start and stop times (J104).	\$306.80
G458A	Single fibre EMG	\$275.00
G875A	Botox for spasticity or dystonia, first injection One treatment per condition per 10 weeks (J52).	\$40.00
G876A	Botox, each additional injection Up to 11 (J51).	\$10.00
G877A	EMG or ultrasound guidance, one Botox injection With G875A alone (J51).	\$18.85
G878A	EMG or ultrasound guidance, two or more Botox injections With G876A (J51).	\$28.10
E543A	Disposable EMG needle electrode, outside hospital With G877A or G878A, once per day (J51).	\$30.60
G485A	Phenol or alcohol nerve block (chemodenervation), first nerve Repeat within 30 days: G487A \$28.50 (J105).	\$45.45
G486A	Chemodenervation, each additional nerve Repeat within 30 days: G488A \$18.80 (J105).	\$28.50
G384A	Trigger point injection	\$8.85
G385A	Each additional trigger point site Up to 2 (J54).	\$4.55
G370A	Joint, bursa, tendon sheath or ganglion injection Add E542A in your office.	\$20.25
G371A	Each additional joint or bursa Up to 5.	\$19.90
G328A	Aspiration of a complex joint (not the knee) or bursa With or without injection; not for injection alone (J53).	\$39.80
G231A	Peripheral nerve block, one nerve or site Nerves not listed elsewhere (J81).	\$34.10
G223A	Each additional nerve or site	\$17.10
G238A	Suprascapular (transverse scapular) nerve block	\$34.10
G264A	Occipital nerve block, first of the day Max 16 first blocks per calendar year (J80).	\$34.10
G265A	Occipital nerve, each additional block Max 3 per day; \$0 unless G264A is paid (J80).	\$17.10
G228A	Paravertebral nerve block	\$34.10
G912A	Lumbar/sacral facet or medial branch block, fluoroscopy Diagnostic; max 6 per 12 months (J75).	\$80.00
G913A	Each additional facet site Max 7 per day (J75).	\$20.00
G914A	Lumbar medial branch block, ultrasound Only after a fluoroscopic block at that site in the last 12 months (J75).	\$56.00
G916A	Sacroiliac joint injection, fluoroscopy Unilateral (J75).	\$75.00
G246A	Lumbar epidural injection Max 12 epidurals (any level) per patient per 12 months without MOH prior authorization (J76).	\$150.00

G918A	Caudal epidural injection Counts toward the 12 per 12 months (J76).	\$74.20
E440A	Epidural with contrast under fluoroscopy Add-on to G246A, G117A, G119A or G918A (J76).	\$30.00
E442A	Epidural by transforaminal technique Add-on to G246A, G117A, G119A or G918A (J76).	\$20.00

Can I bill these together?

Code	With	Together ?	Why
A315A	A425A, A515A, A316A, A313A	No	Only one assessment is paid per visit (GP10).
A313A	A310A, A311A, A318A, A510A, A511A	No	Only one assessment is paid per visit (GP10).
A310A	A311A, A318A, A510A, A511A	No	Only one assessment is paid per visit (GP10).
A311A	A318A, A510A, A511A	No	Only one assessment is paid per visit (GP10).
E078A	A510A, A511A, C510A, C511A	No	E078A isn't payable with complex neuromuscular or complex physiatry assessments (A176).
E078A	A315A, A425A, A515A, A316A, C315A, C313A, C311A	No	E078A only adds to office or clinic medical specific (re-)assessments, complex re-assessments and partial assessments (GP25).
K313A	A315A, A313A, A310A, A311A, A318A, A510A, A511A, H312A, H313A, G456A, G875A, G370A, G384A, G231A, K121A, K002A, K038A, K070A	No	K313A isn't paid if you bill any other service for the patient that day (A180).
A315A,A425A,A313A	G456A, G457A, G473A	Sometimes	If the patient was referred only for the EMG, no consult or assessment is paid unless the referrer also asked for one (J103).
G473A	G456A, G457A	No	Schedule C isn't paid with Schedule A or B the same day (J104).
G471A	G455A, G466A	No	Schedule C technical isn't paid with Schedule A or B technical the same day (J104).
G877A	G878A, G876A	No	G877A is for a single injection; with additional injections (G876A) bill G878A (J51).
G485A	G875A	Sometimes	Chemodenervation into the same muscle the same day as Botox pays \$0; a different muscle is fine (J105).
G370A,G371A,G328A	G912A, G916A, G914A	Sometimes	Not for the same injection: no joint injection code on top of a facet or SI joint injection. A separate joint or bursa injected the same day is paid (J74 rules 5–6 apply only to the same procedure and to injections within that section).
K707A	K730A, K731A	No	No telephone consultation or other case conference with K707A for the same patient the same day (A37).
K731A,K739A	A315A, A425A, A515A, A316A, A313A, A310A, A311A, A318A, A510A, A511A, C315A, C425A, C313A, C311A, C312A	No	The consultant side of a phone or e-consult isn't paid if you also see the patient (consult, assessment or visit) that day or the next (A43, A49).
G231A,G238A,G264A,G228A	G875A, G485A, G370A, G328A, G384A	Sometimes	A block given as the anaesthetic for your own procedure isn't paid; a separate therapeutic block is (J79).
G912A	G916A, G914A	Sometimes	Two injections from this section the same day are paid only when each is for a separate condition (J74).
G700A	A315A, A425A, A515A, A316A, A313A, A310A, A311A, A318A, A510A, A511A	No	G700A is only for a visit where the procedure was the sole reason, and not in hospital (J3).
C122A	C124A	No	C122A and C123A aren't paid the same day as C124A (GP44).
C123A	C124A	No	C122A and C123A aren't paid the same day as C124A (GP44).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C318A	No	MRP premiums are for the MRP; concurrent care means another doctor is the MRP (GP47–GP48).

Code	With	Together ?	Why
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
C142A,C143A	C124A	No	C142A and C143A aren't paid the same day as the discharge visit (GP46).
G264A	G291A	No	G291A pays nil when G264A is paid the same day (J80).
G265A	G292A	No	G292A pays nil when G265A is paid the same day (J80).
G246A,G918A,G117A,G119A	G920A, G234A, G236A	Sometimes	An epidural and a sympathetic block the same day are both paid only for separate conditions (J76).
C312A	H312A	Sometimes	Rehab unit visit limits continue from the acute-care C312A/C317A/C319A count; they don't restart (A180).

Sources: Schedule of Benefits (July 1, 2026): General Preamble GP10–GP69, Physical Medicine A175–A180, Diagnostic and Therapeutic J3, J51–J54, J74–J82 and J103–J105, Practice in General A28–A60 (interviews, case conferences, phone and e-consults, forms), Virtual Care A66–A75. Totals leave out age premiums, which OHIP adds on the remittance. EMG technical fees in hospital are paid at 86.10% and never for in-patients (GP11).

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