

Plastic Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 08 · Office follow-up or post-op · Minor surgery only · Office consultation · Updated October 2026

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

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

Office consultation

A085A	Consultation Written, signed referral on the chart; written report back (GP16). Limit: 1 per 24 months for the same diagnosis.	\$106.25
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
A086A	Repeat consultation Same problem, new written referral, after another doctor cared for the patient in between (GP19).	\$62.80

- 50+ minutes face to face pays A935A (\$194.65), almost double A085A (\$106.25). Write start and stop times (GP19, GP7).
- The consult where you decide to operate is never part of the surgical fee, even when the surgery is the same day (SP2).
- Pre-op consult before carpal tunnel release under local is paid only when the chart shows it was medically necessary (GP18).
- Reduction or augmentation mammoplasty, blepharoplasty and scar revision off the face or neck need Ministry prior approval before surgery (Appendix D, M23).
- One consult per patient per 24 months for the same diagnosis; extras are paid as A083A (GP17).

Office follow-up or post-op

A084A	Partial assessment History of the complaint, the exam needed, advice. Post-op checks, dressing reviews.	\$34.75
A083A	Specific assessment Full history of the complaint and detailed exam of the area. Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$54.40

- The surgical fee covers care only until the first post-op visit; post-op office visits are billed as assessments (SP1).
- A083A is 1 per patient per 12 months (2 with a clearly different, unrelated diagnosis); more are cut to A084A (GP23).
- Suture removal alone is billed as a visit, not a procedure (M15).
- Z procedure booked at an earlier visit: only A084A can be billed before it that day (SP4).
- Dressing changes and debridement after your own surgery aren't billed on top unless a complication needs care beyond the usual post-op care (M10).
- E078A (chronic disease premium) isn't payable to plastic surgery (08): 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.

Minor surgery only

- Lacerations on the face or closed in layers pay almost double: up to 5 cm Z154A \$39.35 vs Z176A \$21.90. Skin glue instead of sutures pays 50% (M15).
- Complex repair: 20+ min of repair plus aligning the vermilion, brow, lid or ear, 3+ layers, or tying multiple bleeders pays Z187A/Z188A (\$101.15). Chart the repair time (M15–M16).
- Lesion closed with an advancement (over 2.5 cm undermining), rotation, transposition or Z-plasty flap: bill the flap, not the excision (M6, M17).
- Several Z procedures at once are each paid in full (SP4). Other procedures under the same anaesthetic: the main one at 100%, the rest at 85% (SP2).
- Trigger finger or keloid injection was the only reason for the visit? G370A, G375A and G377A are + procedures: add G700A (\$8.80) once, outside hospital, with no assessment billed (J3).

Called to ED

A085A	Consultation Referred by the ED doctor.	\$106.25
A935A	Special surgical consultation 50+ min face to face. Chart start and stop times.	\$194.65
A083A	Specific assessment Patient you know, full exam of the problem.	\$54.40
A084A	Partial assessment Brief exam and advice.	\$34.75

- Non-elective call-in: consult + K special visit premium + the procedure. 17:00–07:00, weekends and holidays: also E409A (+50%) or E410A (+75% nights) on the procedure fee (SP2, GP104).

- Bill the A-prefix codes with the premiums and chart the time of the visit (GP65, GP69).
- In hospital, drop E542A from procedure codes: the tray fee is paid only outside hospital (M1, M15).
- Trauma with an injury severity score over 15 (over 12 under age 16): tick E420A for +50% on the consult and surgery; ISS in the chart (GP109).

Hospital in-patient consult

C085A	Consultation, routine Non-emergency in-patient consult.	\$106.25
C935A	Special surgical consultation 50+ min face to face. Chart start and stop times.	\$194.65
A085A	Consultation, called in Non-elective special visit to a ward patient; add the C special visit premiums.	\$106.25
C086A	Repeat consultation Same problem, new request, after another doctor's care in between.	\$62.80
C083A	Specific assessment	\$54.40
C084A	Specific re-assessment	\$34.90
C088A	Concurrent care Another doctor stays MRP and asked you to keep directing care. Limit: 4 in week 1, then 2 a week.	\$31.00

- You can't bill the admission assessment unless it is the visit where you decided to operate (SP2).
- Concurrent care is 4 claims in the first week and 2 a week after; extra claims pay \$0, and E083A never applies to it (GP47–GP48).
- Your own admitted or post-op patient day to day? Use the Hospital rounds tile.

Hospital rounds

C082A	Subsequent visit 1 a day in weeks 1–5. Weeks 6–13: C087A (3 a week); after week 13: C089A (6 a month) (GP43).	\$31.00
C122A	Day after admission, you're the MRP Once per admission; not the same day as C124A/C126A (GP44).	\$71.80
C123A	Second day after admission, you're the MRP Once per admission (GP44).	\$71.80
C142A	First visit after transfer out of ICU, you're the MRP Patient was getting critical, ventilatory or comprehensive care, not just monitoring, and you didn't give that care. One of C122A or C142A per admission (GP46).	\$71.80
C143A	Second visit after transfer out of ICU, you're the MRP Same conditions. One of C123A or C143A per admission (GP46).	\$71.80
C124A	Discharge day, you're the MRP Stay over 48 hours; discharge summary within 48 hours (GP45).	\$71.80
C126A	Discharge day, complex patient Stay of 7+ days, 3+ contributing diagnoses, 45+ minutes. Instead of C124A (A13).	\$95.10
C121A	Extra visit for an acute intercurrent illness After week 5, when the weekly or monthly limit is used up; the limits don't apply to it (GP43).	\$40.05

- As MRP (burns, flaps, trauma), C122A and C123A pay \$71.80 instead of \$31.00 for the first two days after admission (GP44).
- E083A adds 30% to your MRP visits. The E084A weekend premium is not open to Plastic Surgery (08) (GP47).
- Patient came to your ward from the ICU? C142A and C143A replace C122A/C123A; not if you gave the critical care (GP46).
- Visit limits count from the admission date if you admitted the patient, or from the referral date if you were referred in hospital (GP43).
- Palliative patient you're MRP for: C982A (\$40.05) per visit; E083A applies to it (GP47, GP50).

Video or phone

A084A + K300A	Video follow-up, patient you know Paid at 100%.	\$34.75
A084A + K301A	Phone follow-up, patient you know OHIP pays 85% (\$29.54).	\$34.75
A083A + K300A	Specific assessment by video By phone: A083A + K301A, paid at 85%.	\$54.40
A085A + K300A	Consultation by video Video only, never phone.	\$106.25
A101A	Video, no prior relationship Limited virtual care.	\$20.00
A102A	Phone, no prior relationship Limited virtual care.	\$15.00

- Consultations (A085A, A086A, A935A) are video only. A083A and A084A can be video or phone (Appendix J).
- Bill the full fee; OHIP pays 85% for phone (A70).
- If the wound needs an in-person look after all, bill only the in-person visit (A67).

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%
K001A	Detention, per 15 minutes Only after the visit's own time is used up: 60 min for a consult or A083A, 30 min for A084A, 90 min for A935A. Chart start and stop times (GP29–GP31).	\$21.10
E083A	I'm the MRP +30% on MRP subsequent visits, C121A–C143A and C982A. One per patient per day. Not if the hospital pays you for in-patient work (GP47).	+30%
G700A	An injection was the only reason for the visit Once per visit, only when a + procedure was done: G370A tendon sheath or ganglion, G375A/G377A intralesional. Not for Z or R codes alone, not in hospital, not with an assessment (J3).	\$8.80
K036A	Northern Health Travel Grant form Your part of the form for a patient travelling from Northern Ontario. Paid to the referring physician and the specialist (A60).	\$10.25
K070A	Home care referral form You're the most responsible physician sending the patient to Ontario Health atHome (wound or flap care, dressings). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	\$34.75
K730A	Phoned another physician for advice 10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test, or mainly to discuss results. Start and stop times charted. 1 a day. Paid on top of the visit (A42–A43).	\$37.05
K738A	Sent an e-consult to another physician Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months. Paid on top of the visit (A48–A49).	\$16.45
K121A	In-patient case conference, per unit Pre-scheduled, with the MRP and 2+ others (physicians, social workers, regulated health professionals), 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months. Anything done during the conference isn't paid; your visit outside it is (A31–A33).	\$37.05
A084A	Also did a partial assessment Before a Z procedure booked at an earlier visit, a partial assessment is the only visit fee allowed (SP4).	\$34.75

Did a procedure?

Z176A + E542A	Laceration up to 5 cm Simple closure.	\$34.55
Z154A + E542A	Laceration up to 5 cm, face or layered Or tying of bleeders.	\$52.00
Z175A + E542A	Laceration 5.1–10 cm	\$52.00
Z177A + E542A	Laceration 5.1–10 cm, face or layered	\$90.80
Z179A + E542A	Laceration 10.1–15 cm Over 15 cm: Z191A (\$84.70).	\$67.85
Z190A + E542A	Laceration 10.1–15 cm, face or layered Over 15 cm on the face: Z192A (\$169.75).	\$123.85
Z187A	Complex laceration repair, face 20+ min and vermillion, brow, lid or ear alignment, 3+ layers, or multiple bleeders. Includes debridement and foreign body removal.	\$101.15
Z188A	Complex laceration repair, other areas 20+ min and 3+ layers or multiple bleeders.	\$101.15
Z189A	Fingertip (zone 1) complex repair, per digit 20+ min, no soft tissue loss.	\$101.15
Z113A	Skin biopsy, no stitches No tray fee.	\$32.45
Z116A + E542A	Skin biopsy with stitches	\$45.10
Z122A + E542A	Cyst, haemangioma or lipoma, face or neck Local. 2 lesions Z123A, 3+ Z124A (M4).	\$54.85
Z125A + E542A	Cyst, haemangioma or lipoma, other areas Local. 2 lesions Z126A, 3+ Z127A (M4).	\$47.70
Z096A + E542A	Lipoma 5 to 10 cm Over 10 cm: Z097A (\$175.30).	\$100.30
R048A + E542A	Skin cancer excision, face or neck, 1 lesion Pathology report on file. 2 lesions R049A, 3+ R050A (M6). Pre-malignant: R160A, 2 R161A, 3+ R162A (M5).	\$113.60
R094A + E542A	Skin cancer excision, other areas, 1 lesion 2 lesions R040A, 3+ R041A (M6). Pre-malignant: R163A, 2 R164A, 3+ R165A (M5).	\$76.35
R010A	Melanoma wide excision Margins over 1 cm and layered closure.	\$135.95
R011A	Advancement flap, defect 2.1–5 cm, face, neck or scalp Undermining over 2.5 cm a side; includes the excision.	\$89.85
R002A	Advancement flap, defect 2.1–5 cm, other areas Includes the excision.	\$67.40
R045A	Rotation, transposition or Z-plasty, under 2 cm, face, neck or scalp 2.1–5 cm: R046A (\$335.15).	\$203.70
R093A	Full-thickness skin graft, 1–5 cm Under 1 cm R092A (\$116.65); over 5 cm R083A (\$280.15); eyelid, nose, lip or face R091A (\$263.95). Chart the graft size (M19).	\$178.90
R072A	Rotation, transposition or Z-plasty, under 2 cm, other areas 2.1–5 cm: R075A (\$223.35).	\$133.40
R021A	Scar revision up to 2.5 cm, face or neck 2.6–5 cm R022A (\$194.85), 5.1–10 cm R023A (\$277.90). Other areas need prior approval: R026A (\$77.35) (M23).	\$115.60
Z101A + E542A	Abscess or haematoma drainage, local One. Two: Z173A; 3+: Z174A. Palmar or plantar space: Z103A (\$48.60), under GA Z108A (\$78.90) (M1).	\$40.85
Z114A + E542A	Foreign body removal, local Includes removing a contraceptive implant. Under GA: Z115A (\$97.30) (M1).	\$40.30

Z128A + E542A	Nail plate excision, one Multiple: Z129A. With nail bed destruction: Z130A, multiple Z131A (\$90.70) (M23).	\$48.95
Z080A + E542A	Wound or ulcer debridement into fat, one 10+ min, done by you, time charted. Two Z081A, three Z082A, 4+ Z083A; into tendon or bone Z084A.	\$34.55
G370A + E542A	Ganglion or tendon sheath aspiration or injection e.g. trigger finger. Not with surgery on the same site (J53).	\$32.90
G375A	Intralesional injection, 1 or 2 lesions e.g. steroid into a keloid or hypertrophic scar. Paid on top of a visit (J3, J54).	\$10.50
G377A	Intralesional injection, 3 or more lesions J54.	\$15.80
G396A	Injection of extensive keloids J53.	\$24.90
Z137A	Tissue expander inflation, first expander Each additional expander inflated: add E541A (\$11.55), max 3 (M24).	\$23.05
N290A	Carpal tunnel release (booked surgery)	\$197.15

Can I bill these together?

Code	With	Together ?	Why
E078A	A083A, A084A	No	E078A is only paid to the specialties listed in GP25; Plastic Surgery (08) isn't one of them (GP25).
Z080A,Z081A,Z082A,Z083A,Z084A,Z085A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A	No	Wound or ulcer debridement isn't payable with a laceration repair (M10).
Z187A,Z188A,Z189A	Z114A, Z128A, Z129A	No	Complex repair includes foreign body removal, irrigation and debridement; Z114A, Z128A and Z129A aren't paid on top for the same repair (M16).
Z187A,Z188A,Z189A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A	Sometimes	Only for a different wound. Other repair codes aren't paid on top of Z189A for the same zone 1 injury (M16).
R150A,R151A,R152A,R153A,R154A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z191A, Z192A, Z187A, Z188A, Z189A	No	The general plastic surgery codes R150A–R154A can't be used for any laceration repair (M16, M24).
R048A,R049A,R050A,R051A,R052A,R053A,R054A	R011A, R002A, R045A, R072A, R046A, R075A	No	When the excision is closed with an advancement, rotation, transposition or Z-plasty flap, bill the flap code instead of the excision (M6, M17).
A085A,A086A,A087A,A088A,A089A	Z176A, Z154A, Z175A, Z177A, Z113A, Z116A, Z122A, Z125A, Z096A, Z101A, Z114A, Z128A, Z080A, Z187A, Z188A, Z189A, Z137A	Sometimes	Paid when this is the visit where you decided to do the procedure, or it's for an unrelated problem. If you decided at an earlier visit in the last 12 months, only A084A is payable before the Z procedure (SP4).
A084A	Z176A, Z154A, Z175A, Z177A, Z113A, Z116A, Z122A, Z125A, Z096A, Z101A, Z114A, Z128A, Z080A, Z187A, Z188A, Z189A, Z137A	Yes	A partial assessment is payable before a Z procedure, even one booked at an earlier visit (SP4).
A085A,A086A,A087A,A088A,A089A	N290A	Sometimes	A pre-op consultation before carpal tunnel surgery under local or IV sedation is paid only when the chart shows it was medically necessary (GP18).
A085A,A086A,A087A,A088A,A089A	R048A, R094A, R010A, R011A, R002A, R045A, R072A, R093A, R021A, R026A	Yes	The consult where you decide to operate is the major pre-operative visit: never included in the surgical fee, even when the surgery is the same day (SP2, GP4).
A085A,A086A,A087A,A088A,A089A	R048A, R094A, R010A, R011A, R002A, R045A, R072A, R093A, R021A, R026A, N290A	Sometimes	Paid when this is the visit where you decided to operate: the surgical fee never includes that visit (SP2). On a pre-booked surgery day the pre-op check is part of the surgical fee (SP1).
G370A	N290A	No	Joint, ganglion or tendon sheath injection isn't paid with surgery on the same site (J53).
C122A,C123A,C124A,C125A,C126A	C124A, C126A	No	C122A, C123A, C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP44, GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP46).
C123A	C143A	No	Only one of C123A or C143A per admission (GP46).
E083A	C088A	No	E083A is only for the MRP's own subsequent visits, not concurrent care (GP47).
E084A	C082A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Plastic Surgery (08) isn't one.
E541A	Z137A	Yes	E541A is paid for each additional expander inflated with Z137A, up to 3 (M24).

Code	With	Together ?	Why
G700A	A085A, A935A, A086A, A083A, A084A	No	G700A is only for a visit where a + procedure was the sole reason, not with a consult or assessment (J3).
G700A	G370A, G375A, G377A	Yes	G370A, G375A and G377A are + procedures: add G700A once when they're the only reason for the visit, outside hospital (J3).
G700A	Z176A, Z154A, Z175A, Z177A, Z179A, Z190A, Z187A, Z188A, Z189A, Z113A, Z116A, Z122A, Z125A, Z096A, Z101A, Z114A, Z128A, Z080A, Z137A, R048A, R094A, R010A	Sometimes	Z and R codes don't take G700A; it's payable only because a + procedure (G370A, G375A, G377A) was also done that visit (J3).
G375A, G377A, G396A, G370A	A085A, A935A, A086A, A083A, A084A	Yes	Diagnostic and therapeutic procedures are paid on top of a consult or assessment (J3). G370A isn't paid with surgery on the same site (J53).
K036A, K070A, K730A, K738A	A085A, A935A, A086A, A083A, A084A, C124A, C126A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K070A 'in addition to the assessment fee' (A58); K730A and K738A 'in addition to visits or other services' the same day (A42, A48).
K121A	C082A, C122A, C123A, C124A, C126A, C121A, C088A, C085A, C083A, C084A	Yes	Only services rendered during the case conference are not paid; a visit outside it the same day is (A32 rule 4).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (pages in brackets). Surgeon fees only; assistant and anaesthesia units are billed by those physicians. The tray fee E542A is included in procedure totals; drop it in hospital. After-hours (E409A/E410A) and trauma (E420A) premiums on the procedure fee, age premiums for children under 16 (GP64) and special visit premiums are applied by OHIP or added on the claim and aren't all shown here. Cosmetic surgery is uninsured (Appendix D).

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