Radiation Oncology OHIP Billing Cheat Sheet 2026

OHIP specialty 34 · New patient consultation · Clinic follow-up or review · Treatment planning (external beam) · Updated November 2026

Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/radiation-oncology

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

New patient consultation

A345A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same diagnosis: 1 per 2 years. Unrelated diagnosis: 1 per 12 months.	$178.75
A346A	Repeat consultation Same problem you consulted on before, another doctor cared for the patient in between, and a new written referral came in (GP19).	$114.90
A745A	Limited consultation A real referral, but a narrow question that took substantially less time than a full consult (GP19).	$114.90

- Recurrence after another doctor has treated the patient? Ask for a new written referral and bill the repeat consult A346A ($114.90) instead of a re-assessment A340A ($72.00) (GP19).
- Same patient, same diagnosis: 1 consultation per 2 consecutive 12-month periods. A 2nd in the first 12 months is paid as an assessment; a 2nd 12 to 24 months later is still a consult only for an in-patient or ED patient (GP17).
- No written, signed referral on file, or a referral from a medical trainee, means it is paid as an assessment (GP16–GP18).
- The consult is separate from planning: treatment planning X310–X313 is billed once per course on its own (C1–C4).
- Patients under 16: OHIP adds 10% to 30% to specialist consultations on the remittance (GP64).

Clinic follow-up or review

A340A	Re-assessment Full relevant history and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	$72.00
A341A	Complex re-assessment, letter to the family doctor Complex, obscure or serious condition. Send your findings in writing to the primary care physician or it is paid as a lesser fee (GP24). Limit: 4 per 12 months (shared with A343A).	$83.40
A343A	Full assessment of a new problem, no referral Full history of the presenting complaint and a detailed exam of the affected systems (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	$95.95
A348A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit (GP25).	$44.75

- Order to reach for: A341A ($83.40) when the problem is complex and you write to the family doctor, then A340A ($72.00), then A348A ($44.75) (GP23–GP25).
- A340A is limited to 2 per patient per 12 months, and A343A + A341A together to 4. Past those OHIP pays a lesser fee, so a 3rd complex visit with a letter is better billed as A341A (GP23–GP24).
- E078A (+50%) is in your listing, but only for a visit coded with a GP26 chronic disease (e.g. 250 diabetes). The list has no cancer codes, so never add it to a cancer follow-up (A195, GP25–GP26).
- Cancer conference (MCC) fees K708A and K709A aren't payable to radiation oncology (A29).
- Driving concern after brain treatment? The MTO report K035A ($36.25) is paid on top of the visit (A59).

Treatment planning (external beam)

X310	Level 1, simple planning Planning that doesn't meet Level 2, 3 or 4 criteria (C2). Limit: 1 per patient per course.	$215.35
X311	Level 2, intermediate planning e.g. 2–4 field cases with contour or 2D computerized dose distribution, contrast or insertion, extended SSD, standard shielding, simple wax or Pb cut-out (C2). Limit: 1 per patient per course.	$374.60
X312	Level 3, complex planning e.g. 5 and 6 field cases, whole CNS, 4-field conformal, 8-field, total or hemi-body, CT or MRI scan for planning, custom shielding (Cerrobend), compensators, custom immobilization (C3). Limit: 1 per patient per course.	$680.45
X313	Level 4, full 3D preparation Oriented in 2+ axes with full 3D target definition, 3D dose computation and plan evaluation; or paediatric, stereotactic, total skin electron, total body irradiation or IMRT (C4). Limit: 1 per patient per course.	$811.15

- Pick the highest level the course qualifies for: any CT or MRI scan used for planning makes it at least Level 3 (X312, $680.45), and IMRT or stereotactic makes it Level 4 (X313, $811.15) (C3–C4).

- One planning fee per patient per course. Once X310–X313 is payable, no other radiation oncology planning or treatment service in that course is paid, and all later plan changes by any physician are included (C1).
- You must personally prepare the medical part of the plan and supervise planning and dose calculation. Planning outside an Ontario public hospital funded by Ontario Health for radiotherapy is payable at nil (C1).
- Urgent case started in the evening, on a weekend or holiday, or at night (e.g. cord compression)? Tick the after-hours premium, and the travel premium if you came in. Not for work done outside the hospital, such as remote review (GP105).
- Several patients on the same after-hours call? Each patient after the first takes the additional-person code instead: C105A evening, C106A weekend or holiday, C107A night, same fees (GP105–GP106).

Brachytherapy (sealed sources)

X323	Intracavitary application, first Radium or sealed sources, including a D&C done at the same time (C5).	$356.45
X334	Intracavitary application, repeat Each later application (C5).	$178.35
X324	Interstitial application Radium or sealed radioisotope (C5).	$356.45
X325	Plaque or mould application In-patient or out-patient. As an out-patient service in a hospital it is paid to the registered Department of Radiology (C5).	$111.25

- Did the dose calculation and prepared the applicator or device yourself? Tick X322 ($113.65), the sealed-source planning fee (C5).
- X322, X323, X324, X325 and X334 outside an Ontario public hospital are payable at nil (C1).
- When external beam planning X310–X313 is paid for the same course, other radiation oncology planning and treatment in that course isn't (C1).
- The application fee includes preparing the patient, the procedure itself and monitoring through recovery (C1).

Radioisotope therapy (unsealed)

X329	Metastatic disease of bone Includes planning, dosage and preparation of the material (C6).	$100.00
X336	Prostate malignancy (C6).	$100.00
X326	Thyroid malignancy Includes every administration in any 3-month period (C6).	$100.00
X327	Hyperthyroidism Includes every administration in any 3-month period (C6).	$80.00
X335	Induction of hypothyroidism Includes every administration in any 3-month period (C6).	$80.00
X330	Malignant ascites or pleural effusion Drainage is billed on top (C6).	$100.00
X328	Polycythemia (C6).	$100.00
X332	Arthritis, one or more sites (C6).	$80.00

- A visit and procedures such as paracentesis are paid on top of the isotope fee: tick the visit here and the drainage in the procedure panel (C6).
- Thyroid fees X326, X327 and X335 cover all doses in any 3-month period; don't bill a second one inside it (C6).
- Planning, dosage calculation and preparing the material are included; there's no separate planning fee for unsealed sources (C6).

Called to the ED

A345A	Consultation ED doctor's request on the chart; report back to them.	$178.75
A343A	Full assessment, no consult request e.g. your own patient sent in to you.	$95.95
A340A	Re-assessment Your own patient you assessed recently.	$72.00
A348A	Quick look or advice	$44.75

- Not on ED duty and seeing a patient in the ED? Bill the A-code from the general listings plus the ED special visit premiums (K960A travel, K990A–K999A person seen) (A195, GP70).
- Also did urgent radiation oncology work (e.g. planning) on the same call? The after-hours diagnostic premiums C102A–C110A aren't paid on top of the ED premiums for the same special visit: claim one set (GP105).

- A 2nd consult for the same problem 12 to 24 months after the first is still paid as a consult in the ED or in hospital (GP17).
- Admitting the patient as MRP? This consult is the admission assessment: add E082A (+30%) (GP40, GP42).
- Stayed with an unstable patient? Detention K001A ($21.10 per 15 min) starts after 60 minutes of a consult (GP29–GP31).

In-patient consult

C345A	Consultation Requested by the attending doctor; written report on the chart.	$178.75
C745A	Limited consultation Narrow question, substantially less time than a full consult (GP19).	$114.90
C346A	Repeat consultation Same problem after another doctor's care, new request (GP19).	$114.90
C343A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	$95.95
C344A	Re-assessment e.g. admitting a patient you assessed for the same illness.	$72.00
C341A	Complex re-assessment Complex, obscure or serious condition; findings in writing to the primary care physician (GP24).	$83.40
A345A	Called urgently to see another doctor's in-patient Emergency call to the ward: bill A-prefix codes and the in-patient special visit premiums (A195, GP65).	$178.75

- Urgent call to the ward: bill A345A, not C345A, and add the in-patient special visit premiums for the time of day (A195, GP65–GP72).
- Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission. Not for transfers within the hospital, and not if the hospital pays you for in-patient work without reducing it (GP42).
- Seen your own patient for the same illness and now admitting them: the admission assessment is a re-assessment (C344A, $72.00), not C343A (GP40).
- Seeing the patient in the ICU or CCU: add C101A ($9.10) per patient, unless critical care team fees are billed (GP103).

Hospital rounds

C122A	MRP visit, day after admission Once per admission (GP44).	$71.80
C123A	MRP visit, 2nd day after admission Once per admission (GP44).	$71.80
C142A	MRP, 1st visit after transfer out of ICU Patient was getting critical, ventilatory or comprehensive care, not just monitoring. Instead of C122A (GP46).	$71.80
C342A	Subsequent visit Weeks 1–5: C342A. Weeks 6–13: C347A, max 3 a week. After week 13: C349A, max 6 a month (A195).	$40.05
C124A	MRP, day of discharge Discharge summary within 48 h. Not if the stay was under 48 h (GP45).	$71.80
C126A	MRP, discharge of a complex patient Stay 7+ days, 3+ diagnoses that lengthened it, 45+ minutes of your time. Instead of C124A (A13).	$95.10
C348A	Concurrent care (family doctor stays MRP) 4 the first week, then 2 a week (GP48).	$40.05
C121A	Extra visit for an intercurrent illness Outside the weekly limits (GP43).	$40.05
C982A	Palliative care visit As MRP, for a patient receiving palliative care (GP50).	$40.05

- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays; radiation oncology is on the E084A list. One per patient per day (GP47).
- C122A + E083A = $93.34 versus a plain C342A at $40.05: bill the MRP codes on days 1, 2 and discharge.
- Complex discharge (7+ day stay, 3+ diagnoses, 45+ minutes): C126A pays $95.10, $23.30 more than C124A (A13).
- Concurrent care C348A takes no E083A/E084A: you aren't the MRP (GP47–GP48).

Counselling, family or palliative support

K013A	Counselling or education Booked visit only for advice and education. First 3 units per patient per 12 months (with K040A).	$80.00
K033A	Counselling, after the first 3 units this year	$56.30
K023A	Palliative care support Pain and symptom management, emotional support and counselling for a palliative patient. Start and stop times charted (A2).	$85.25
K002A	Interview with relatives or substitute decision-maker Separately booked, about the patient's care. Billed on the patient's number.	$80.00
K015A	Counselling relatives of a terminally ill patient Billed on the ill patient's number.	$80.00

- Counselling, interviews and palliative care support can be billed by any specialty (GP9). 20 minutes of K023A pays $85.25, more than A340A ($72.00).
- Units are by time: 20 min = 1 unit, 46 = 2, 76 = 3. Chart the start and stop times or it is paid at a lesser fee (A2, GP55).
- With counselling K013A/K033A, no consult or assessment is paid the same day. Shots, blood draws, K002A/K015A, the MTO report, the travel grant form and your own phone call for advice are allowed (GP58).

Phone, video or advice to a doctor

A345A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	$178.75
A340A + K300A	Video re-assessment Full fee.	$72.00
A340A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	$72.00
A341A + K301A	Phone complex re-assessment, letter to family doctor 85% of $83.40.	$83.40
A348A + K301A	Phone quick follow-up 85% of $44.75.	$44.75
K731A	Phone call with the referring doctor or NP, 10+ minutes Patient-related discussion; chart start and stop times, reason and your advice (A42–A44). Limit: 1 per patient per day.	$47.75
K739A	E-consultation through a secure server Opinion sent within 30 days (A48).	$20.50

- Video pays 100%, phone 85%. A video re-assessment is worth $10.80 more than the same visit by phone (Appendix J, A70).
- Patient must have seen you in person in the last 24 months, or had a video consult with you (A66).
- In-patient C-codes (C341A, C343A–C346A, C745A) are video only (Appendix J).
- K731A and K739A need the referring doctor's or NP's billing number, and aren't paid if you see the patient the same or next day: bill the visit (A43, A49).

Also bill, if it's true

E082A	I'm admitting as MRP: admission premium +30% of the admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	I'm the MRP, weekday +30% on subsequent visits, C121A–C143A and C982A. One of E083A/E084A per patient per day (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A (GP47).	+45%
C101A	Patient is in the ICU or CCU Per patient seen. Not with critical care or ventilatory team fees (GP103).	$9.10
K001A	Stayed with the patient: detention, per 15 min Active treatment or monitoring to the exclusion of other work, after 60 min of a consult (40 for a re-assessment, 30 for A348A). Not for waiting (GP29–GP31).	$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	$80.00
X322	Sealed-source planning, dosage and device preparation You personally prepared the medical plan and supervised dose calculation; includes all later adjustments in the course (C1, C5).	$113.65
C109A	Non-elective, started weekday evening 17–24 Urgent radiation oncology service, in the hospital, for an acute-care in-patient, out-patient or ED patient. Not for remote work. 1 per patient per call; max 2 per period (GP105).	$61.70
C108A	Non-elective, started Sat, Sun or holiday 07–24 Max 6 per period (GP105).	$77.10
C110A	Non-elective, started at night 00–07 No maximum (GP105).	$102.80
C102A	I travelled to the hospital: weekday evening One per trip. Not when you were already on the campus (GP65, GP105).	$37.40
C103A	I travelled to the hospital: Sat, Sun or holiday One per trip (GP65, GP105).	$37.40
C104A	I travelled to the hospital: night One per trip (GP65, GP105).	$37.40
A343A	Also assessed the patient: full assessment Visits are paid in addition to unsealed isotope fees (C6).	$95.95
A340A	Also assessed the patient: re-assessment Visits are paid in addition to unsealed isotope fees (C6).	$72.00
A341A	Also assessed the patient: complex re-assessment, letter to the family doctor Visits are paid in addition to unsealed isotope fees (C6).	$83.40
A348A	Also assessed the patient: quick look or advice Visits are paid in addition to unsealed isotope fees (C6).	$44.75
G489A	Blood draw	$3.54
G372A	Injection with the visit Each injection (J54).	$4.55
K035A	Reported a medical condition to the MTO (driving) 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
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 they already get home care. Paid on top of the visit (A58–A59).	$34.75
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 (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 (A48).	$16.45
K121A	Hospital case conference, per unit Pre-scheduled; the MRP plus 2 other physicians or regulated professionals; 10+ min about this patient. Max 4 per patient per 12 months. Not for radiation treatment planning (A31–A33).	$37.05

Did a procedure?

X337	Fiducial markers into the prostate Includes any imaging or guidance; images taken for it aren't paid to any physician (C4).	$122.30
X338	Rectal spacer placement Includes any imaging or guidance (C4).	$223.65
X339	Fiducial markers into the vagina Includes any imaging or guidance (C4).	$76.45
X305	Contact x-ray intracavitary planning, first application Includes sigmoidoscopy or proctoscopy. Payable at nil outside an Ontario public hospital (C1, C4).	$170.85
X306	Contact x-ray intracavitary planning, repeat application Payable at nil outside an Ontario public hospital (C1, C4).	$85.50
X302	Teleradiotherapy treatment visit, 150 kVp or higher Per treatment visit. Not for staff of a hospital funded by Ontario Health for radiotherapy (C1, C4).	$15.90
X304	Minor teleradiotherapy, 150 kVp or less Per treatment visit. Same staff restriction (C1, C4).	$11.95
Z591A	Paracentesis with drainage With or without a sample. Outside hospital add E542A $12.65 (S34).	$57.65
Z590A	Diagnostic paracentesis (sample only) (S34).	$31.30
Z332A	Thoracentesis Diagnostic or therapeutic. Outside hospital add E542A $12.65 (P14).	$104.40
E542A	Tray fee: paracentesis or thoracentesis outside hospital Add to Z590A, Z591A or Z332A done in the office (P14, S34).	$12.65
G373A	Injection was the only reason for the visit First injection; each extra one G372A (J54).	$7.90

Can I bill these together?

Code	With	Together?	Why
X310	X311, X312, X313	No	Planning is one level per patient per course of treatment; bill the highest level the course qualifies for (C1–C4).
X311	X312, X313	No	One planning level per patient per course (C1–C4).
X312	X313	No	One planning level per patient per course (C1–C4).
X310,X311, X312,X313	X302, X304, X305, X306, X322, X323, X324, X325, X334	No	When X310–X313 is payable, any other radiation oncology planning or treatment service in the same course isn't (C1).
X326,X327, X328,X329, X330,X332, X335,X336	A345A, A343A, A340A, A341A, A348A, C345A, C343A, C344A, C341A, C342A	Yes	Unsealed isotope fees include planning and preparation; visits are paid in addition (C6).
X326,X327, X328,X329, X330,X332, X335,X336	Z591A, Z590A, Z332A	Yes	Procedures such as paracentesis are paid in addition to unsealed isotope fees (C6).
X305	X306	No	X305 is the first application, X306 a repeat one; bill the one that matches (C4).
X323	X334	No	X323 is the first intracavitary application, X334 a repeat one (C5).
A345A	A343A, A340A, A341A, A348A, A745A, A346A	No	A consultation already includes the assessment; bill one consult or assessment for the visit (GP16).
C345A	C343A, C344A, C341A, C745A, C346A	No	One consultation or assessment per visit (GP16).
E078A	A345A, A745A, A346A, C345A, C343A, C344A, C341A, C342A	No	E078A goes only on office or out-patient medical specific assessments, re-assessments, complex re-assessments and partial assessments; not consultations or in-patient visits (GP25).
K013A	A345A, A343A, A340A, A341A, A348A, A745A, A346A	No	With counselling no consultation or assessment is paid the same day (GP58).
K033A	A345A, A343A, A340A, A341A, A348A	No	With counselling no consultation or assessment is paid the same day (GP58).
K013A,K033A	K002A, K015A, G489A, G372A, K035A, K036A, K730A	Yes	These are on the list of services allowed with counselling (GP58).
K002A	A345A, A343A, A340A, A341A, A348A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A,K739A	A345A, A343A, A340A, A341A, A348A, C345A, K013A	No	Phone or e-consult isn't paid if you see the patient the same day or the next day; bill the visit (A43, A49).
K730A,K738A	A345A, A343A, A340A, A341A, A348A, C345A, C343A, C344A, C341A, C342A	Yes	Your own phone or e-consult as the referring doctor is paid in addition to the visit (A42, A48).
K035A,K036A,K070A	A345A, A745A, A346A, A343A, A340A, A341A, A348A, C345A, C343A, C344A, C341A, C342A	Yes	These forms and reports are paid on top of the visit (A58–A60).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C348A	No	MRP premiums only go on visits by the MRP; concurrent care means the family doctor is MRP (GP47–GP48).
C122A,C123A,C142A, C143A	C124A, C126A	No	C122A/C123A/C142A/C143A aren't paid the same day as the discharge visit (GP44, GP46).

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).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C102A,C103A,C104A,C105A,C106A,C107A,C108A,C109A,C110A	K960A, K962A, K963A, K964A, K990A, K994A, K996A, K998A, C960A, C962A, C963A, C964A, C990A, C994A, C996A, U990A, U994A, U996A, U998A	No	The after-hours diagnostic premiums aren't paid on top of any other special visit premium for the same visit (GP105).
C108A,C109A,C110A	X310, X311, X312, X313, X322, X323, X324, X325, X334	Sometimes	Only for a non-elective service started in the premium hours, for an acute-care hospital in-patient, out-patient or ED patient, and not for work done outside the hospital (GP105).
K001A	A345A, A343A	Sometimes	Detention starts only after 60 minutes of the consult or assessment, for active treatment or monitoring, not waiting (GP29–GP30).
Z332A,Z591A,Z590A	A343A, A340A, A341A, A345A	Sometimes	Z-codes are independent procedures: if your major pre-procedure visit was in the last 12 months, only a partial assessment (A348A) is paid before it that day (SP4).
K023A	K002A, K013A, K015A, K033A, K035A, K036A, K070A, K730A, K731A, K738A, K739A, K121A	No	Other Family Practice & Practice in General listings, such as these, aren't paid with palliative care support K023A (A2).
E542A	Z590A, Z591A, Z332A	Sometimes	E542A is added only when the paracentesis or thoracentesis is done outside hospital (P14, S34).
G373A	A345A, A343A, A340A, A341A, A348A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A per injection (J54).

From the Ontario Schedule of Benefits (effective July 1, 2026): Radiation Oncology listings A195–A196, the Radiation Oncology section C1–C6, General Preamble GP16–GP105 and Appendix J. Cancer conference fees K708A/K709A aren't payable to radiation oncology (A29). External beam planning outside an Ontario public hospital funded for radiotherapy, and contact x-ray or sealed-source work outside an Ontario public hospital, are payable at nil (C1). Totals leave out the age premium on specialist consultations for patients under 16 (+10% to +30%, GP64), which OHIP adds on the remittance. Phone visits are shown at the 85% OHIP pays. Check your remittance advice if a fee looks different.

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