

Respiratory Disease OHIP Billing Cheat Sheet 2026

OHIP specialty 47 · Pulmonary function and tests · ICU team fee (per diem) · Counselling or interview · Updated October 2026

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

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

Office consultation

A475A	Consultation Written, signed referral on file; full history of the problem, exam and a written report back to the referring doctor (GP16). Limit: Same problem: 1 per 2 years. Unrelated problem: 1 per 12 months.	\$192.30
A470A	Comprehensive consultation, 75+ minutes face to face All the elements of a consultation plus at least 75 minutes of direct contact. Record start and stop times or it is paid as a lesser fee. Time on separately billed tests (spirometry, oximetry) and chart or imaging review does not count (A197).	\$342.25
A575A	Limited consultation A real referral, but a narrow question that took much less time than a full consult (GP19).	\$119.35
A476A	Repeat consultation Same problem you consulted on before, the patient was cared for by another doctor in between, and a new written referral came in (GP19).	\$119.35

- Spent 75+ minutes face to face? A470A pays \$342.25, \$149.95 more than A475A. Chart start and stop times; spirometry or a 6-minute walk you bill separately doesn't count toward the 75 (A197).
- Same patient, same problem: only 1 consultation per 2 consecutive 12-month periods. A 2nd within the first 12 months is paid as an assessment. Exception: a 2nd consult 12 to 24 months later in hospital or the ED (GP17).
- Spirometry, flow-volume loop and oximetry done at the visit are paid on top: tick them under Did a procedure or test? (J3, H4).
- No written referral on file, or one requested after the visit, means it is paid as an assessment (GP16).

Office follow-up

A474A	Re-assessment Full history of the problem and exam of one or more systems. Limit: 2 per 12 months, then paid as a lesser fee.	\$75.30
A471A	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 A473A).	\$89.40
A570A	Complex respiratory assessment Ongoing management of chronic respiratory failure (PaO2 < 60 or PaCO2 > 50), bronchiectasis with frequent infections, cystic fibrosis, active TB, or active non-TB mycobacterial disease. Needs re-assessment elements (A197). Limit: 6 per 12 months.	\$108.95
A473A	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).	\$102.60
A478A	Quick look or advice History of the complaint, the exam needed, advice, chart note. No yearly limit.	\$45.25

- Asthma (493), COPD (491, 492) or pulmonary fibrosis (515)? Tick E078A: +50% on A473A, A474A, A471A or A478A in the office or a hospital clinic. A474A + E078A = \$112.95, more than A570A (\$108.95) (GP25–26).
- A570A is for the listed complex conditions only, not routine COPD follow-up; E078A can't be added to it (A198).
- A473A and A471A share a limit of 4 per patient per 12 months; A474A is 2 per 12 months. Extras are paid as a lesser fee (GP23–24).
- A471A + E078A = \$134.10 when the problem is complex and you send a letter to the family doctor. Asked another specialist for advice by phone (K730A, 10+ min) or e-consult (K738A)? Paid on top of the visit (A42, A48).
- E078A is not paid in the ED, in hospital or in LTC, and needs an established chronic diagnosis on the claim (GP25).

Pulmonary function and tests

- Outside a hospital, only spirometry and flow-volume loops (J301, J304, J324, J327) pay a technical part. For every other test only the reading is paid (C suffix); the technical part comes from the facility fee (H3).
- Bill the technical part with suffix B and the reading with suffix C (H3).
- Spirometry and a flow-volume loop aren't both paid the same day: the loop with bronchodilator (J304 + J327) pays more (H4).
- Every spirometry needs the best of 3 efforts and your written interpretation; a computer interpretation alone isn't paid (H4).
- Not for routine pre-op screening before non-thoracic surgery, or for patients with no symptoms, signs or guideline indication (H3, H6).

Called to the ED

A475A	Consultation ED doctor's request on the chart; report back to them.	\$192.30
A470A	Comprehensive consultation, 75+ minutes face to face Record start and stop times.	\$342.25
A473A	Full assessment, no consult request e.g. your own patient sent in to you.	\$102.60
A474A	Re-assessment Your own patient you assessed recently.	\$75.30
A478A	Quick look or advice	\$45.25
• If you admit the patient, this ED consult is the admission assessment: don't bill a second one. As MRP, add E082A (+30%) to it (GP40, GP42). • Not on ED duty when called? Bill your A-code plus the ED special visit premiums (K960A travel, K990A–K999A person seen). Never with H-codes (GP65, GP70). • No E078A chronic disease premium in the ED (GP25). • Stayed with an unstable patient? Detention K001A (\$21.10 per 15 min) starts after 60 minutes of a consult or 120 of A470A (GP30–31). • Respiratory failure or another vital organ failure? Life-threatening critical care: G521A \$125.10 first 15 min, G523A \$64.50 the second, G522A \$42.50 each 15 min after. Only time at the bedside or on the patient's floor, start and stop times charted; intubation, lines and blood gases are included (J26–J27).		

In-patient consult

C475A	Consultation Requested by the attending doctor; written report on the chart.	\$185.80
C470A	Comprehensive consultation, 75+ minutes face to face Same conditions as A470A: start and stop times charted.	\$342.25
C575A	Limited consultation Narrow question, much less time than a full consult.	\$115.30
C476A	Repeat consultation Same problem after another doctor's care, new request.	\$115.30
C473A	Admission or full assessment, no consult Your own patient you admit, not seen for this illness in the last 90 days (GP40).	\$99.15
A475A	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 (GP43). Pays more than C475A.	\$192.30
• Admitting as MRP? Add E082A (+30%) to the admission assessment, once per admission. Not for transfers within the hospital (GP42). • Seen your patient for the same illness in the last 90 days? The admission assessment is a re-assessment (C474A, \$72.80), not C473A (GP40). • In-patient with one of the A570A conditions: C570A (\$105.25) pays more than C474A (A199). • Seeing patients in the ICU: add C101A (\$9.10) per patient, unless critical care or ventilatory 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.	\$71.80
C142A	MRP, 1st visit after transfer out of ICU Patient was getting critical, ventilatory or comprehensive care, not just monitoring. Replaces C122A (GP46).	\$71.80
C472A	Subsequent visit Weeks 1–5: 1 a day. Weeks 6–13: C477A, 3 a week. After week 13: C479A, 6 a month (GP43).	\$40.05
C124A	MRP, day of discharge Discharge summary within 48 h (reason, procedures, diagnosis, meds). Not if stay 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
• As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays. One per patient per day (GP47). • C122A + E083A = \$93.34 versus a plain C472A at \$40.05: claim 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). • Ventilated patient outside the ICU: chronic ventilatory care G404A (\$61.00) (J31). • Following while another doctor is MRP? That's concurrent care C478A (\$40.05): 4 the first week, then 2 a week, no E083A (GP48).		

ICU team fee (per diem)

G557A	Comprehensive care, 1st day You give all ICU care: critical care and ventilatory support. Includes the consult, intubation, ventilation, lines, blood gases, defibrillation and cardioversion (J31–J32).	\$429.30
G558A	Comprehensive care, days 2–30 Per day (J32).	\$256.25
G559A	Comprehensive care, day 31 on Per day (J32).	\$122.80
G405A	Ventilatory support only, 1st day You run the ventilator; someone else gives the critical care. Includes the consult, intubation, lines and blood gases (J31).	\$183.80
G406A	Ventilatory support, days 2–30 Per day. Day 31 on: G407A \$64.20 (J31).	\$96.45
G400A	Critical care, no ventilator, 1st day All other care of a critically ill ICU patient. Includes the consult, lines, catheters and lab interpretation (J31).	\$223.10
G401A	Critical care, days 2–30 Per day. Day 31 on: G402A \$58.60 (J31).	\$146.45

- These are team fees: one per patient per day, billed as if one physician were in charge even when the attending changes (J30).
- Not for stable patients or those in the ICU only for monitoring, unless they're on a ventilator. Bill consults and visits instead (J30–J31).
- With a per diem, no life-threatening or other critical care codes (G521A–G523A, G395A) and no C101A that day (J27–J28, J30, GP103).
- Back in the ICU more than 48 hours after leaving it: the 1st-day rate applies again. Moved from comprehensive to critical or ventilatory care, or from critical to comprehensive care: the transfer day counts as day 2 (J30–J31).
- Swan-Ganz insertion Z438A (\$162.50) isn't included in the team fees and is billed on top (J7). After transfer out, C142A then C143A (\$71.80) go to the ward MRP, not to the physician who billed the team fee (GP46).

Counselling or interview

K013A	Counselling or education Booked visit only for advice and education (inhaler technique, new diagnosis, home oxygen). First 3 units per patient per 12 months.	\$80.00
K033A	Counselling, after the first 3 units this year	\$56.30
K002A	Interview with relatives or substitute decision-maker Separately booked, about the patient's care, not only for consent.	\$80.00
K015A	Counselling relatives of a dying patient Billed on the ill patient's number.	\$80.00

- Counselling is open to every specialty (GP9). 20 minutes of K013A pays \$80, more than A474A (\$75.30).
- With counselling, no consult or assessment the same day. Shots are allowed (GP58).
- Book it as its own appointment and chart start/stop times: 20 min = 1 unit, 46 = 2, 76 = 3 (GP54, GP58).
- Allowed with counselling the same day: vaccines, injections (G372A), K730A phone advice, K035A MTO report, K036A travel grant form. Spirometry and other tests are not on that list (GP58).

Advice to another doctor

K731A	Phone call with the referring doctor or NP, 10+ minutes Patient-related discussion; chart start/stop times, reason and your advice (A43–A44). Limit: 1 per patient per day.	\$47.75
K739A	E-consultation through a secure server Opinion sent within 30 days (A48). Limit: 6 per patient per 12 months, 400 a year.	\$20.50
K733A	Call arranged by CitiCall Ontario Patient and referrer in Ontario (A45).	\$47.75
K735A	Phone consult while you're on ED duty Use instead of K731A when on shift in an ED or urgent care clinic.	\$47.75

- Put the referring doctor's or NP's billing number on the claim or it isn't paid.
- Not paid if you see the patient the same day or the next day: bill the visit instead (A43, A49).
- Not paid when the call is to arrange a transfer, a visit or a test, or mainly to discuss PFT or imaging results.

Phone or video

A475A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	\$192.30
A474A + K300A	Video re-assessment Full fee.	\$75.30
A474A + K301A	Phone re-assessment Bill the in-person fee; OHIP pays 85%.	\$75.30
A570A + K301A	Phone complex respiratory assessment 85% of \$108.95.	\$108.95
A478A + K301A	Phone quick follow-up 85% of \$45.25.	\$45.25

- E078A (+50% of what's paid for the virtual visit) is still payable on phone and video re-assessments for asthma, COPD or fibrosis (A74). Tick it above.
- Video pays 100%, phone 85%. Patient must have seen you in person in the last 24 months, or had a video consult with you (A66).
- The patient (or a needed follow-up) must start it. Calls only to give normal results aren't billable. Record phone or video in the chart.

Also bill, if it's true

E078A	Established chronic disease on the claim +50%. Office or hospital clinic only. Diagnostic code from the GP26 list: asthma 493, chronic bronchitis 491, emphysema 492, pulmonary fibrosis 515 (and others). Not with A570A.	+50%
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 and C121A–C143A. 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 (120 for A470A, 40 for a re-assessment). Not for waiting (GP29–31).	\$21.10
K002A	Also met the family 20+ min, separately booked Per unit. Not the history-taking for today's visit (GP61).	\$80.00
A475A	Also saw the patient: consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$192.30
A473A	Also saw the patient: full assessment of a new problem, no referral Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$102.60
A474A	Also saw the patient: re-assessment Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$75.30
A471A	Also saw the patient: complex re-assessment, letter to the family doctor Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$89.40
A478A	Also saw the patient: quick look or advice Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$45.25
A470A	Also saw the patient: comprehensive consultation, 75+ minutes face to face Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$342.25
A575A	Also saw the patient: limited consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$119.35
A476A	Also saw the patient: repeat consultation Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$119.35
A570A	Also saw the patient: complex respiratory assessment Only when the family interview was separately booked, 20+ min, and not the history-taking for this visit (GP61).	\$108.95
G590A	Flu shot	\$8.80
G846A	Pneumococcal vaccine	\$8.80
G849A	RSV vaccine Paid on top of the visit (J3, J54).	\$8.80
G593A	COVID-19 vaccine Paid on top of the visit (J3, J54).	\$13.00
G372A	IM or SC injection given at the visit Each injection, e.g. a biologic you give in clinic (J54).	\$4.55
K730A	Phoned another doctor for advice, 10+ min You keep the patient's care. Paid on top of your visit. Not to arrange a referral, transfer or test, or mainly to discuss results; not paid if the consultant sees the patient that day or the next. 1 per patient per day (A42–A43).	\$37.05
K738A	Sent an e-consult for advice Secure server, answer within 30 days. Paid on top of your visit. 1 per patient per day, 6 per 12 months (A48–A49).	\$16.45
K035A	Reported a medical condition to the MTO Mandatory report under the Highway Traffic Act. More than 1 per 12 months for the same patient: manual review (A59).	\$36.25

K070A	Filled in a home care referral form You're the doctor giving the patient ongoing care and completed it yourself. Paid on top of the visit. Once per Ontario Health atHome admission; not if already receiving home care (A58–A59).	\$34.75
K036A	Northern Health Travel Grant form Paid to both the referring doctor and the specialist (A60).	\$10.25
G521A	Life-threatening critical care, up to 15 min Vital organ failure with imminent risk of death. Time at the bedside or on the floor, no other patients meanwhile; start and stop times charted (J26–J27).	\$125.10
G521A + G523A	Life-threatening critical care, 16–30 min First and second quarter hour (J26).	\$189.60
G522A	Critical care, each further 15 min after 30 Tick with 16–30 min. 4th and later physicians bill G391A \$34.35 per 15 min instead (J26).	\$42.50

Did a procedure or test?

J301B + J301C	Spirometry in your office Best of 3 efforts, written interpretation (H4).	\$18.70
J301B + J301C + J324B + J324C	Spirometry before and after bronchodilator, office	\$26.15
J304B + J304C	Flow-volume loop in your office Graphs to scale; your own interpretation and training (H4).	\$34.40
J304B + J304C + J327B + J327C	Flow-volume loop before and after bronchodilator, office Not the same day as J301/J324.	\$45.30
J304C + J327C	Flow-volume loop pre/post, reading only (hospital lab) Professional component.	\$20.50
J307C	Lung volumes by body box, reading Not with gas dilution J311 the same day (H5).	\$21.35
J311C	Lung volumes by gas dilution, reading	\$21.00
J310C	Diffusing capacity (DLCO), reading	\$21.55
J306C	Airways resistance, reading	\$19.20
J340C	Maximum inspiratory/expiratory pressures, reading	\$3.81
J333C	Methacholine or histamine challenge, reading	\$41.55
J330C	Exercise-induced asthma test, reading	\$27.25
J315C	Graded exercise test (Stage I), reading You must be in attendance throughout (H3).	\$56.45
J316C	Steady-state exercise test (Stage II), reading	\$72.70
J332C	Oximetry at rest and exercise, or overnight, reading Not with exercise tests, stress tests or echo (H6).	\$11.35
J336C	Home oxygen eligibility test, reading Room air vs oxygen with single-blind exercise. Not with J332/J334 (H6).	\$16.85
J896C	Overnight sleep study, first ever (Level 1), reading 1 per lifetime. Reader must meet CPSO sleep medicine standards (J108–J109).	\$97.50
J897C	Repeat diagnostic sleep study, reading Only for listed re-evaluation reasons; 1 per facility per 12 months (J110).	\$97.50
J895C	CPAP titration sleep study, reading	\$97.50
Z327A	Bronchoscopy, with or without biopsy	\$124.90
E636A	Bronchoalveolar lavage, add to Z327A	\$50.00
E638A	Transbronchial lung biopsy, add to Z327A	\$81.90
E677A	TBNA of mediastinal or hilar nodes, add to Z327A TBNA of a lung mass: E678A \$104.00 (P10).	\$104.00
G050A	EBUS-guided biopsy of hilar or mediastinal nodes Endobronchial ultrasound (P10).	\$203.05
E837A	Each additional EBUS biopsy, add to G050A Up to 3 (P10).	\$50.75
Z332A	Thoracentesis Diagnostic or therapeutic. Outside hospital add E542A \$12.65 (P14).	\$104.40
Z361A	Indwelling pleural catheter insertion Malignant effusion, palliative. Includes image guidance. Removal Z362A \$200.00; adjusting one is a visit (P15).	\$200.00
Z336A	Needle pleural biopsy Includes diagnostic aspiration.	\$59.15
Z341A	Chest tube	\$76.80
Z459A	Arterial puncture for blood gas	\$10.20

Can I bill these together?

Code	With	Together ?	Why
A475A	A473A, A474A, A471A, A478A, A570A, A575A, A476A	No	A consultation already includes the assessment; bill one or the other for the visit (GP16).
A470A	A475A, A473A, A474A, A471A, A478A, A570A	No	A470A replaces A475A when you spent 75+ minutes; it already includes the assessment (A197, GP16).
C470A	C475A, C473A, C474A, C471A, C570A	No	One consultation or assessment per visit; C470A replaces C475A when 75+ minutes (A199).
E078A	A570A	No	E078A is not paid the same day as A570A (A198).
E078A	A473A, A474A, A471A, A478A	Yes	E078A adds 50% to these in the office or a hospital clinic, with a listed chronic diagnosis (GP25–26).
E078A	A475A, A470A, A575A, A476A	No	E078A only goes on assessments, not consultations (GP25).
E078A	C473A, C474A, C471A, C472A, C570A	No	E078A isn't paid for in-patients, LTC residents or ED patients (GP25).
K013A	A475A, A470A, A473A, A474A, A471A, A478A, A570A, A575A, A476A	No	With counselling no consultation or assessment is paid the same day (GP58).
K002A	A475A, A473A, A474A, A471A, A478A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A, K739A	A475A, A470A, A473A, A474A, A471A, A478A, A570A, C475A	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).
J301, J324	J304, J327	No	Spirometry isn't paid the same day as a flow-volume loop (H4).
J307	J311	No	Body box and gas dilution lung volumes aren't both paid the same day (H5).
J323	J332, J315, J316, G315A, G319A	No	Resting oximetry isn't paid with exercise oximetry, exercise or stress tests, echo or a sleep study (H6).
J332	J315, J316, G315A, G319A, J896, J897	No	Exercise or overnight oximetry isn't paid with exercise tests, stress tests, echo or an overnight sleep study (H6).
J336	J332, J334	No	The home oxygen test isn't paid with J332 or J334 (H6).
E636A, E638A, E677A	Z327A	Yes	These are add-ons to the bronchoscopy, Z327A (P9).
J301, J324, J304, J327, J307, J311, J310, J306, J305, J303, J340, J308, J333, J335, J330, J315, J316, J323, J332, J334, J336, J896, J897, J895, J893, J894	A475A, A470A, A575A, A476A, A473A, A474A, A471A, A478A, A570A, C475A, C470A, C575A, C476A, C473A, C474A, C471A, C570A	Yes	Pulmonary function tests (H1–H6) have no same-day rule against a consultation or assessment, and sleep studies are D&T services paid on top of one (J3); bill both. Their own limits: J301/J324 not with J304/J327, J307 not with J311, the oximetry rules (H4–H6).
K730A, K738A	A475A, A470A, A575A, A476A, A473A, A474A, A471A, A478A, A570A, C475A, C470A, C575A, C476A, C473A, C474A, C471A, C570A, K002A	Yes	The referring doctor's phone or e-consult is paid in addition to visits the same day (A42, A48). 10+ min for K730A; not to arrange a referral, transfer or test (A43, A49).
K738A	K013A, K033A, K015A	No	K738A isn't on the list of services allowed the same day as counselling (GP58 rule 1).

Code	With	Together ?	Why
K730A	K013A, K033A, K015A	Yes	K730A is on the list of services allowed the same day as counselling (GP58), and is paid in addition to other services (A42).
K035A,K036A,K070A	A475A, A470A, A575A, A476A, A473A, A474A, A471A, A478A, A570A	Yes	Forms and reports are paid on top of the visit; K070A "in addition to the assessment fee" (A58–A60).
Z327A,Z332A	A473A, A474A, A471A	Sometimes	If the procedure was planned at an earlier visit, only a partial assessment (A478A) is paid before it that day (SP4).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C478A	No	MRP premiums only go on visits by the MRP; concurrent care means someone else is MRP (GP47–48).
C122A,C123A,C142A,C143A	C124A, C126A	No	C122A/C123A/C142A/C143A aren't paid the same day as the discharge visit (GP44, GP46).
C122A	C142A	No	Only one of C122A or C142A per admission (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C101A	G400A, G405A, G521A, G557A	No	C101A isn't paid with critical care or ventilatory care team fees (GP103).
K001A	A470A	Sometimes	After a comprehensive consultation detention starts only past 120 minutes, for active treatment, not waiting (GP29–31).
G521A,G523A,G522A	G211A, G268A, G269A, Z459A, Z437A	No	Intubation, lines, blood gases, defibrillation and cardioversion are included in life-threatening critical care (J26).
G521A,G523A,G522A	G395A	No	Other critical care G395A isn't paid with G521A, G522A or G523A the same day (J28).
G521A,G523A,G522A,G395A	G400A, G401A, G402A, G405A, G406A, G407A, G557A, G558A, G559A	No	Critical care time codes aren't paid the same day as a critical care, ventilatory or comprehensive care per diem (J27–J28).
G521A,G523A,G522A	A475A, A470A, A473A, A474A, C475A, C473A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and that time isn't counted (J26–J27).
G400A,G405A,G557A	C475A, C470A, C473A, C101A	No	The day-1 team fee includes the initial consultation and assessment, and C101A isn't paid with team fees (J31–J32, GP103).
Z438A	G557A, G405A, G400A	Yes	Swan-Ganz insertion isn't included in respiratory or critical care benefits (J7).
Z360A	Z327A, G521A, G395A	No	No other bronchoscopy, and no life-threatening or other critical care, with emergency rigid bronchoscopy Z360A (P9).
Z363A	Z341A	No	Chest tube removal isn't paid the same day as its insertion (P14).

From the Ontario Schedule of Benefits (effective July 1, 2026): Respiratory Disease listings A197–A199, General Preamble GP16–GP103, Pulmonary Function Studies (H1–H6), Sleep Studies (J107–J114), Critical Care (J26–J32) and Respiratory Surgical Procedures (P9–P15). Respiriology services not listed there are billed from Internal Medicine (A197). Lookup fees for tests are technical + professional together; in the office or reading for a hospital lab you get the parts shown under Did a procedure or test? 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.