

Rheumatology OHIP Billing Cheat Sheet 2026

OHIP specialty 48 · Injection-only visit · Yearly RA management fee · Infusion or drug supervision · Updated October 2026

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

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

Office consultation

A485A	Consultation Written referral on file, full consult, written report back to the referring doctor (GP16).	\$202.40
A590A	Comprehensive consultation, 75+ min All consult elements plus 75+ minutes face to face, not counting joint injections or chart and imaging review. Start and stop times in the chart (A200).	\$342.25
A595A	Limited consultation Referred for a narrower question that needs substantially less time than a full consult (GP19).	\$124.50
A486A	Repeat consultation Same problem, new written referral, and another doctor treated the patient since your first consult (GP19).	\$125.10

- 75+ minutes face to face? A590A pays \$342.25 instead of \$202.40. Time spent injecting joints doesn't count toward the 75, and start and stop times must be charted (A200).
- Injected or aspirated a joint at the consult? Both are paid: open the procedure panel (J3).
- Limited (A595A, \$124.50) and repeat (A486A, \$125.10) consults pay more than a medical specific assessment (\$95.95). Use them whenever there is a new written referral (GP19).
- One consult per patient per diagnosis per 2 consecutive 12-month periods. A second for the same problem is only paid as an in-patient or ED consult 12–24 months later, or as a repeat consult (GP17).
- No written, signed referral in the chart: OHIP pays it as an assessment (GP16).

Follow-up visit

A484A	Medical specific re-assessment Full relevant history and exam of one or more systems. Limit: 2 per patient per 12 months (GP23).	\$72.00
A481A	Complex re-assessment Complex, obscure or serious condition. Written findings must go to the family doctor (GP24). Limit: 4 per 12 months, combined with A483A (GP24).	\$83.40
A480A	Complex rheumatology assessment Ongoing care of vasculitis, inflammatory myopathy, polymyalgia rheumatica or paediatric vasculitis. Includes re-assessment elements; not for your first evaluation (A200). Limit: 6 per patient per 12 months (A200).	\$113.85
A483A	Medical specific assessment Full history of the complaint and detailed exam of the affected systems; new problem, no referral. Limit: 1 per 12 months (2 for a clearly different diagnosis) (GP23).	\$95.95
A488A	Partial assessment History of the complaint, the exam needed, advice, record. No yearly limit.	\$44.75

- RA, lupus, scleroderma, myositis, AS or other spondyloarthropathy (dx 714, 710, 720, 721): tick E078A for +50%. A484A becomes \$108.00, A481A \$125.10, A483A \$143.93 (GP25–26).
- A481A + E078A (\$125.10) beats A480A (\$113.85). A480A is for vasculitis, myositis and PMR, and takes no E078A (A200).
- E078A is only for office or hospital out-patient clinic visits, not ED, in-patients or LTC (GP25).
- Over a limit, OHIP cuts the visit to a lesser fee: A484A 2 per 12 months, A483A 1 per 12 months, A483A + A481A together 4 per 12 months, A480A 6 per 12 months (GP23–24, A200). Past those, bill A488A (+ E078A).
- Each visit counts toward the 3 needed for the yearly K481A RA fee (A202). Phoned or e-consulted another physician about the patient (e.g. nephrology for lupus)? K730A or K738A is paid on top of the visit (A42, A48).

Injection-only visit

- Injection was the only reason for the visit? Add G700A (\$8.80) once, because G370A is a + procedure. Not in hospital (J3).
- Aspirating a complex joint (anything but a normal knee) pays G328A \$39.80, nearly double G370A. Not for an injection alone (J53).
- A knee only counts as complex when distorted by RA, lupus, dermatomyositis, Still's disease, AS or another spondyloarthropathy (J53).
- Only one of G370A, G371A, G328A, G329A per joint or bursa. Olecranon bursa is always G370A/G371A. Hyaluronic acid injections are uninsured (J53).
- Outside hospital, add E542A (\$12.65) to the first G370A or G328A (J53).

Yearly RA management fee

K481A	Rheumatoid arthritis management by a specialist You are most responsible for this RA patient, 3+ consults or assessments with them in the 12 months, 100+ RA patients a year, and all 7 measures recorded (A202). Limit: 1 per patient per 12 months.	\$85.35
- Records needed for the 12 months: tender and swollen joint counts, physician and patient global, pain score, function (HAQ or SF-36), ESR or CRP, and a DAS-28, SDAI or CDAI (A202). - Video and phone visits count toward the 3 required visits (A75). - Submit K481A only after the 12 months of elements are done (A202).		

Infusion or drug supervision

G381A	Standard IV therapy Minor-toxicity agents such as cyclophosphamide, methotrexate or zoledronic acid; biologics only if a monoclonal antibody or cytokine (J57).	\$54.50
G345A	Complex IV therapy Agent that can cause infusion reactions or organ toxicity needing immediate intervention, e.g. rituximab (J57).	\$75.00
G359A	Special IV therapy Major toxicity, frequent monitoring and long administration, e.g. high-dose cyclophosphamide (> 1 g/m ²) (J57).	\$105.15
G382A	Monthly phone supervision of therapy for autoimmune disease Supervision by telephone, once a month (J58).	\$13.95
- G381A, G345A and G359A include venipuncture, the IV line and giving the drug, and all assessments by any physician for 24 hours after (J57). - You must be available to intervene for the whole infusion (J57). - Blood products, insulin and vaccines are not biologic agents for these codes (J57).		

Hospital in-patient consult

C485A	Consultation, routine request Seen on your own schedule.	\$201.95
C590A	Comprehensive consultation, 75+ min Same conditions as A590A: 75+ minutes face to face, start and stop times charted (A205).	\$342.25
C595A	Limited consultation Narrower question, substantially less time.	\$124.50
C486A	Repeat consultation Same problem, new request, another doctor treated in between.	\$124.50
A485A	Called in urgently to see another doctor's patient Non-elective call. Bill the A code; the in-patient special visit premiums apply (GP43, GP69).	\$202.40
- Urgent call to the ward: bill A485A, not C485A, and add the special visit premiums for the time of day. Chart the time of the visit (GP43, GP69). - Joint aspiration at the bedside is paid on top of the consult (J3). - If you admit the patient as most responsible physician, this consult is your admission assessment: add E082A (+30%) (GP40, GP42). - Seen in ICU or CCU? Add C101A (\$9.10) per patient (GP103).		

Emergency department consult

A485A	Consultation Requested by the ED physician; report copy back to them.	\$202.40
A590A	Comprehensive consultation, 75+ min Start and stop times charted (A200).	\$342.25
A483A	Medical specific assessment Your own patient, or no consult request.	\$95.95
A484A	Medical specific re-assessment Patient you saw recently for the same problem.	\$72.00
- Called in from outside the hospital: travel plus first-person premiums apply. Evenings, weekends and nights pay more (GP66, GP70). - Hot joint tapped in the ED? Add G370A or G328A from the procedure panel; no E542A in hospital (J53). - No E078A in the ED (GP25).		

Hospital follow-up (rounds)

C482A	Subsequent visit, first 5 weeks 1 per day. Weeks 6–13: C487A (3 per week). After week 13: C489A (6 per month). Count from the day you were referred (GP43).	\$40.05
C122A	You're MRP: day after admission Once per admission; C142A instead if the day after transfer out of ICU (GP44, GP46).	\$71.80
C123A	You're MRP: second day after admission Once per admission; C143A instead after an ICU transfer.	\$71.80
C124A	You're MRP: day of discharge Stay 48+ hours, discharge summary within 48 hours, follow-up and discharge meds arranged (GP45).	\$71.80
C126A	You're MRP: complex discharge Stay 7+ days, 3+ diagnoses that lengthened it, 45+ min on the discharge (A13).	\$95.10
C488A	Concurrent care Family doctor stays MRP and asked you to keep directing care: 4 in the first week, then 2 per week (GP48).	\$40.05

- MRP? Every subsequent visit gets E083A (+30%), or E084A (+45%) on Saturday, Sunday or a holiday. Not with concurrent care (GP47).
- MRP day-after-admission and second-day visits pay \$71.80, not \$40.05 (GP44).
- After week 5, an acute intercurrent illness beyond the limits is C121A (\$40.05) (GP43).
- In-patient re-assessments also exist: C483A \$95.95, C484A \$72.00, C481A \$83.40, C480A \$112.00 (A205).

Video, phone or e-consult

A484A + K300A	Video follow-up Patient you've seen in person in the last 24 months, or consulted by video. Full fee (A66).	\$72.00
A484A + K301A	Phone follow-up Phone pays 85% of the in-person fee (A70).	\$72.00
A485A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	\$202.40
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit or transfer, or mainly about results (A42–A43).	\$47.75
K739A	e-Consult reply Opinion through a secure server within 30 days. Max 6 per patient per 12 months, 400 a year (A48).	\$20.50
K480A	Phone call with an Arthritis Society PT, OT or social worker 10+ minutes about your established patient; start and stop times, names, reason and your advice charted. Max 1 a day, 2 per 12 months (A203).	\$31.35

- E078A still applies by video or phone: 50% of the virtual fee (A74).
- K480A is paid on top of a visit the same day (A204). K731A and K739A are not, if you see the patient that day or the next (A43, A49).
- A480A, A481A, A483A, A484A and A488A can be done by phone; every consult and in-patient C code is video only (Appendix J).
- The patient has to start the contact (or it's a needed follow-up of one). A check-in call you start isn't billable (A68).

Also bill, if it's true

E078A	Chronic disease premium (+50%) Established diagnosis on OHIP's list (714 RA, 710 lupus/scleroderma/dermatomyositis, 720 AS, 721 other spondyloarthropathies and others). Office or out-patient clinic only. Put that diagnostic code on the claim (GP25–26).	+50%
E082A	You admitted them as MRP (+30%) This consult is your admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	You're the MRP (+30%) Weekday subsequent visit as most responsible physician (GP47).	+30%
E084A	You're the MRP, Saturday, Sunday or holiday (+45%) Only one of E083A or E084A per patient per day (GP47).	+45%
C101A	Patient seen in ICU or CCU Not with critical care, ventilatory or comprehensive care team fees (GP103).	\$9.10
G372A	IM or SC injection with the visit e.g. methotrexate, steroid IM. Each injection (J54).	\$4.55
G700A	The injection was the only reason for the visit Once per visit when a + procedure (G370A) was done. Not in hospital, not with an assessment (J3).	\$8.80
G700A	The infusion was the only reason for the visit G381A is a + procedure: add G700A once when no consult or assessment is billed that day. Not in hospital (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
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

Did a joint injection or procedure?

G370A + E542A	Joint, bursa, ganglion or tendon sheath injection or aspiration Outside hospital. In hospital bill G370A alone (\$20.25) (J53).	\$32.90
G370A	Same, in hospital (no tray fee)	\$20.25
G371A	Each additional joint, bursa or tendon sheath Up to 5 more (J53).	\$19.90
G328A + E542A	Complex joint or bursa aspiration, with or without injection Any joint but a normal knee. Outside hospital. In hospital G328A alone (\$39.80). Not for injection only (J53).	\$52.45
G328A	Complex joint aspiration, in hospital	\$39.80
G329A	Each additional complex joint or bursa aspirated Up to 2 more (J53).	\$20.25
E446A	Image-guided repeat after a failed blind attempt Add to G370A or G371A. Imaging fees for the guidance are not payable (J53).	\$30.00
G384A	Trigger point injection	\$8.85
G385A	Each additional trigger point site Up to 2 more.	\$4.55
G373A	IM/SC injection was the only reason for the visit First injection; more injections are G372A (J54).	\$7.90
G381A	Standard IV therapy supervised e.g. IV methotrexate, cyclophosphamide, zoledronic acid (J57).	\$54.50
G345A	Complex IV biologic supervised e.g. rituximab (J57).	\$75.00
G389A	Gamma globulin prepared and infused Per patient per day (J55).	\$13.90
G489A	Blood drawn in your office	\$3.54
G009A	Urinalysis with microscopy, in your office e.g. lupus or vasculitis. Result, your interpretation and the treatment decision charted (J65, J68).	\$4.90
G010A	Urine dipstick only, in your office Without microscopy. Result, interpretation and decision charted (J65, J68).	\$2.64

Can I bill these together?

Code	With	Together ?	Why
A485A,A590A,A595A,A486A	A483A, A484A, A481A, A488A, A480A	No	Only one consultation or assessment is paid for the same visit (GP10).
A480A	E078A	No	E078A is not payable with A480A (A200).
A480A	A485A, A590A, A595A, A483A	No	A480A is for ongoing management; it is not paid for your initial evaluation of the patient (A200).
E078A	A483A, A484A, A481A, A488A	Yes	E078A adds 50% to a medical specific assessment, re-assessment, complex re-assessment or partial assessment in the office or out-patient clinic (GP25).
E078A	C483A, C484A, C481A, A485A, A590A, C485A	No	E078A only adds to office or out-patient assessments, not consultations, in-patient, ED or LTC services (GP25).
K481A	A483A, A484A, A481A, A480A, A488A	Yes	No same-day restriction is listed; claim once the 12 months of required elements are complete (A202).
K480A	A483A, A484A, A481A, A480A, A488A, A485A, K481A	Yes	K480A is payable in addition to visits or other services the same day (A204).
K731A,K739A	A485A, A590A, A483A, A484A, A481A, A480A, A488A, C485A, C482A	No	Not paid when the consultant sees the patient (consult, assessment, visit or K time code) the same day or the next day (A43, A49).
G370A	G371A, E542A, E446A	Yes	Additional joints (G371A), the out-of-hospital tray fee (E542A) and image-guided repeat (E446A) all add to G370A (J53).
G328A	G329A, E542A	Yes	Additional complex joints (G329A) and the out-of-hospital tray fee (E542A) add to G328A (J53).
G370A,G371A	G328A, G329A	Sometimes	Only one of G370A, G371A, G328A, G329A per bursa or joint. Different joints are fine (J53).
E446A	G328A, G329A	No	E446A only adds to G370A or G371A (J53).
G370A,G328A	A485A, A590A, A483A, A484A, A481A, A480A, A488A	Yes	Joint injections and aspirations are paid on top of the consult or assessment (J3).
G381A,G345A,G359A	A483A, A484A, A481A, A480A, A488A, C482A	Sometimes	The infusion fee includes all assessments by any physician for 24 hours after the treatment (J57).
G373A	A485A, A590A, A483A, A484A, A481A, A480A, A488A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A (J54).
G373A	G372A	Yes	Sole-reason visit: the first injection is G373A and each additional injection G372A (J54).
G700A	G381A	Yes	G381A is a + procedure, so G700A is added once when the infusion is the only reason for the visit, outside hospital (J3).
K036A,K730A,K738A	A485A, A590A, A595A, A486A, A483A, A484A, A481A, A480A, A488A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K730A and K738A 'in addition to visits or other services' the same day (A42, A48).
K121A	C482A, C122A, C123A, C124A, C126A, C488A, C485A, C483A, C484A, C481A, C480A	Yes	Only services rendered during the case conference are not paid; a visit outside it the same day is (A32 rule 4).
G009A,G010A	A485A, A590A, A595A, A486A, A483A, A484A, A481A, A480A, A488A	Yes	Office lab tests are paid on top of the consult or assessment when the result, interpretation and decision are charted (J3, J65).
G700A	A485A, A590A, A595A, A486A, A483A, A484A, A481A, A480A, A488A	No	G700A is only for a visit where a + procedure was the sole reason, not with an assessment (J3).

Code	With	Together ?	Why
K013A,K033A	A483A, A484A, A481A, A480A, A488A	No	With counselling, no consult or assessment is paid the same day (GP58).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C488A, C485A, C483A	No	E083A/E084A only add to subsequent visits by the MRP, not consults or concurrent care (GP47).
E082A	C482A, C122A, C123A, C124A, C126A, E083A	No	E082A only adds to the MRP's admission assessment and no other service or premium (GP42).
C122A,C123A	C124A, C126A	No	C122A and C123A aren't paid the same day as a discharge visit (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).

From the Ontario Schedule of Benefits (effective July 1, 2026): Rheumatology pages A200–A205, the General Preamble and Diagnostic & Therapeutic Procedures (J3, J53–J58). Rheumatology has no long-term care listing; the Schedule sends you to Internal Medicine for services it doesn't list (A200). OHIP adds age premiums on the remittance (GP64: +10% to +30% on specialist consultations and procedures for patients under 16), so they are not in these totals. Video and phone amounts assume OHIP's 85% phone rate; E078A on a virtual visit is 50% of the virtual fee. Procedures that need a tray fee include E542A (\$12.65) in the price shown. 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.