General Thoracic Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 64 · Called to ED or ward · Pleural or bedside procedure · Bronchoscopy, EBUS or mediastinoscopy · Updated November 2026

Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/thoracic-surgery

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

Office consultation

A645A	Consultation Written referral from a physician or NP; written report back. Limit: 1 per patient per 2 years for the same diagnosis (GP17).	$100.15
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart review. Chart start and stop times (GP7, GP19–GP20).	$194.65
A646A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	$60.95

- 50+ minutes face to face? A935A pays $194.65, $94.50 more than A645A. Procedure time and charting don't count (GP19–GP20).
- This is usually your decision-to-operate visit: it's paid on top of the surgery whenever the surgery happens (SP2).
- Did a Z-code procedure (thoracentesis, chest tube, bronchoscopy) today that you decided on at this consult? Bill both. Next time, only a partial assessment (A644A) can go before a planned Z-code procedure (SP4 §13).
- A second consult for the same diagnosis within 2 years is paid as a specific assessment, unless it's a repeat consult or an in-patient/ED consult 12–24 months later (GP17).
- Lung or oesophageal cancer case presented at a scheduled cancer conference? K708A ($37.05) is paid the same day as the visit (A29).

Office follow-up

A644A	Follow-up or post-op visit History of the problem, the exam needed, advice. Partial assessment.	$24.50
A643A	Full work-up of one problem Full history of the complaint and detailed exam of the affected part. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	$45.10

- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1).
- Your office has no specific re-assessment code: routine follow-ups are A644A. A643A is limited to 1 a year per patient (2 for a clearly different diagnosis) (GP23).
- Planned Z-code procedure today (e.g. thoracentesis, chest tube removal) decided at an earlier visit? A644A is the only visit payable before it (SP4 §13).
- Phoned or e-consulted another physician about this patient? K730A ($37.05) or K738A ($16.45) is paid on top of today's visit. Gave the advice yourself? K731A ($47.75) or K739A ($20.50), but not if you see the patient that day or the next (A42–A49).
- E078A (chronic disease premium) isn't payable to thoracic surgery (64): GP25 limits it to 13 other specialties.

Called to ED or ward

A645A	Consultation Requested by the ED or ward physician. Written report.	$100.15
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	$194.65
A646A	Repeat consultation Same problem, new request, after another physician's care in between.	$60.95
A643A	Full work-up, your own patient Specific assessment.	$45.10
A644A	Brief assessment Partial assessment.	$24.50

- Seeing patients in the ED or out-patient department, or called to an in-patient, when you're not on ED duty: use these A-codes plus the special visit premiums, not C-codes (A109, GP65).
- The premiums shown are the ED table (I). For an in-patient on a ward (table III) or an out-patient clinic (table II) bill that table's codes (GP71–GP72).
- Weekday daytime chest tube or other non-elective procedure: consult + special visit premium + procedure. Evenings, nights, weekends: add E409A or E410A to the procedure (SP2 §2, GP104).
- Admitting the patient as MRP? E082A adds 30% to this consult, once per admission (GP42).
- Taking the patient to the OR? Pick the operation's tile (lung, oesophagus or chest wall) and tick the after-hours premium there.

Pleural or bedside procedure

- Chest tube removal (Z363A, $20.00) isn't paid the same day as the insertion (Z341A) (P14).
- Thoracentesis done outside hospital adds the tray fee E542A ($12.65); it's built into the office choice below (P14).
- Indwelling pleural catheter insertion or removal (Z361A/Z362A, $200.00) includes any image guidance. Adjusting one already in place is a visit, not Z361A (P15).
- Tracheo-bronchial aspiration (Z344A) isn't paid to the operating surgeon or in the first 2 hours after surgery (P11).
- Local anaesthetic or sedation you give for your own procedure isn't paid separately (SP5 §20).

Bronchoscopy, EBUS or mediastinoscopy

Z327A	Bronchoscopy, flexible or rigid With or without bronchial biopsy, suction or contrast. Add what you did below (P9).	$124.90
G050A	EBUS-guided biopsy of hilar or mediastinal nodes Extra biopsies by EBUS: E837A, max 3 (P10).	$203.05
Z329A	Mediastinoscopy P13.	$380.00
Z330A	Mediastinoscopy with bronchoscopy One code for both, $110.00 more than Z329A (P13).	$490.00
Z348A	Mediastinoscopy with bronchoscopy and mediastinotomy With mediastinotomy only: Z328A ($475.80). Anterior mediastinotomy alone: Z347A ($300.00) (P13).	$605.85
Z335A	Thoracoscopy (pleuroscopy) With or without pleural biopsy, suction (P14).	$242.35
Z399A	Oesophagoscopy-gastroscopy Elective. Oesophagoscopy alone: Z515A ($68.25) (S7).	$92.50
Z360A	Emergency rigid bronchoscopy, obstructed airway Life-threatening emergency, patient not intubated. No other bronchoscopy code with it (P9).	$474.65

- Bronchoscopy with a laryngoscopy or oesophagoscopy: only the bronchoscopy is paid (P9).
- Mediastinoscopy and bronchoscopy at one sitting: bill the listed combination Z330A ($490.00), not two codes (P13).
- TBNA of nodes (E677A) or of a lung mass (E678A) adds $104.00 each to Z327A; a transbronchial lung biopsy adds E638A ($81.90) (P9–P10).
- Bronchoscopy right after your thoracic operation under the same anaesthetic isn't paid, and one on the day of a major lung resection isn't paid if you scoped the patient in the previous 3 weeks (P9).
- Two Z-code procedures at one sitting (e.g. bronchoscopy and thoracoscopy) are each paid in full; the 85% rule is for adding an M- or S-code operation (SP4 §13, SP2 §3).

Lung resection or pleura (OR)

M143A	Lobectomy May include radical mediastinal node dissection or sampling (P16).	$1,753.25
M144A	Segmentectomy Including segmental bronchus and artery (P16).	$1,802.20
M145A	Wedge resection of lung Each more wedge: E608A, max 3 (P16–P17).	$1,054.25
M142A	Pneumonectomy May include radical node dissection, sampling or pericardial resection with repair (P16).	$2,125.00
M149A	Pleurectomy and/or apical bullectomy for pneumothorax P16.	$525.00
M151A	Bullectomy for major bullous disease P16.	$725.00
M135A	Major decortication for empyema or tumour P14.	$848.80
M137A	Thoracotomy, with or without biopsy Hilar node or lung biopsy with full thoracotomy: M138A ($534.10) (P14, P16).	$390.65

- Done by VATS, robotic or uniportal approach? E683A adds 35% to M142A, M143A, M144A, M145A, M149A and M151A (P16).
- Mediastinoscopy or bronchoscopy before the resection, same anaesthetic: the resection is paid in full and the other at 85% (SP2 §3). Not a bronchoscopy right after the resection (P9).
- E644A ($400.00) is only for radical mediastinal node dissection after preoperative chemotherapy or radiotherapy; otherwise node work is part of M142A and M143A (P16).
- E618A ($426.50) needs 60+ minutes of decortication or lysis of adhesions on top of everything else, with start and end times in the chart (P17).
- BMI over 40: E676A adds 25% to M142A, M143A or M144A only when done open under general anaesthetic, never thoracoscopically (SP6).

Oesophagus or hiatus (OR)

S091A	Hiatus hernia repair with fundoplication Abdominal or transthoracic (S9).	$750.00
S079A	Massive paraoesophageal hernia Over 50% of the stomach in the chest with fundus above the GE junction, or stomach plus another organ through the crus (S9).	$1,200.00
S092A	Recurrent hiatus hernia S9.	$1,100.00
S161A	Oesophageal myotomy, partial (below aortic arch) With hiatus hernia repair: E758A. Total thoracic myotomy: S100A ($841.35) (S9).	$584.15
S090A	Total thoracic oesophagectomy With reconstruction: E730A (S8).	$1,912.30
S089A	Partial oesophagectomy with reconstruction Including intestinal transposition (S8).	$1,180.50
S096A	Ruptured oesophagus, suture and drainage S9.	$1,200.00
S088A	Cricopharyngeal (Zenker) diverticulum Not with an open cricopharyngeal myotomy S086A (S8).	$390.05

- Laparoscopic or thoracoscopic hiatus hernia repair: E793A adds 25% to S091A, S092A or S079A (S9).
- S079A pays $450.00 more than S091A, but only for the paraoesophageal hernias described on S9: chart the anatomy.
- Myotomy with a hiatus hernia repair: bill S161A or S100A plus E758A ($217.35), not S091A (S9).
- Oesophagectomy, myotomy, diverticulum or enucleation by VATS, robotic or uniportal approach: E683A adds 35% (S9–S10).
- Hiatus hernia repair with cholecystectomy or vagotomy: E742A ($217.35) for each. Other combinations follow the 85% rule (S9, SP2).

Chest wall, mediastinum or trauma (OR)

M106A	Mediastinal tumour P12.	$1,255.00
M105A	Chest wall tumour resection, 2+ ribs (or wide resection of one rib for malignancy) Not for rib resection as exposure, or for a biopsy (P12).	$1,040.00
M116A	Rib fixation for trauma Each rib beyond four: E604A (P12).	$550.00
M117A	Sternal fixation for trauma P13.	$251.45
M112A	Sternal debridement and rewiring As sole procedure (P12).	$500.00
M132A	Diaphragm repair or plication, thoracic approach Ruptured diaphragm or plication (P14).	$900.00
N284A	First or cervical rib excision Includes scalenotomy, fibrolysis and neurolysis when required (P12).	$714.00
R352A	Pectus excavatum or carinatum repair By reconstruction, not implant (P13).	$1,331.70

- Mediastinal tumour, thoracic duct ligation or rib fixation by VATS, robotic or uniportal approach: E683A adds 35% to M106A, M108A or M116A (P12–P13).
- Chest wall defect of 5 cm+ closed with synthetic material: add E640A ($179.55); each rib beyond 3, E601A ($57.50, max 3 more) (P12).
- Incisional chest wall biopsy (Z353A) and excisional rib biopsy (Z354A) aren't paid the same day as M105A (P12).
- Trauma patient with ISS over 15 (over 12 under 16): E420A adds 50% to your consult and operation within 24 hours. ISS in the chart (GP109).
- Non-elective case started 17:00–24:00 weekdays or any time on a weekend/holiday: E409A +50%; 00:00–07:00: E410A +75% (GP104).

In-patient or LTC consult

C645A	Consultation Requested by the attending physician, routine (not a called-in visit).	$100.15
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	$194.65
C646A	Repeat consultation	$60.95
C643A	Full work-up Specific assessment.	$45.10
C644A	Re-assessment Specific re-assessment. 2 per 12 months except admissions (GP23).	$26.40
C648A	Concurrent care You keep following the patient while another physician is the MRP. Limit: 4 in week 1, then 2 a week (GP48).	$31.00
W645A	Long-term care consultation Chronic care or convalescent hospital, nursing home, home for the aged (A110).	$100.15
W646A	Long-term care repeat consultation A110A.	$60.95

- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2).
- Called in urgently to another physician's patient (ward or long-term care)? Use the ED or ward tile: A-codes plus the premiums (GP43, GP65).
- Second surgeon brought in on consultation who then operates or assists may also claim the consult, justified on an IC basis (SP3 §8).
- Concurrent care is 4 claims in the first week and 2 a week after; it never takes E083A (GP47–GP48).

Hospital rounds

C122A	Day after admission, you're the MRP Once per admission (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 and you didn't give it. 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
C642A	Routine daily visit Weeks 1–5; then C647A (3 a week) and C649A (6 a month) (A109).	$31.00
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 (A13).	$95.10
C121A	Extra visit for an acute intercurrent illness After week 5, when the weekly or monthly limit is used up (GP43).	$40.05

- As MRP after surgery, C122A and C123A pay $71.80 instead of $31.00 for the first two days (GP44).
- E083A adds 30% to your MRP visits (GP47). The E084A weekend premium isn't open to thoracic surgery (GP47).
- Visit limits after week 5 count from the admission date if you admitted the patient, or from the referral date if referred in hospital (SP2).
- Palliative patient you're MRP for: C982A ($40.05) per visit, and E083A applies to it (GP47, GP50).
- Surgery cancelled before induction counts as a subsequent visit; after induction with you scrubbed, bill E006A (SP7 §27).

Also bill, if it's true

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 tick G391A instead (J26).	$42.50
G395A	Other critical care (resuscitation), first 15 min Threat to life or limb that, without your resuscitation, would likely need life-threatening critical care or cost the limb. Not with G521A–G523A the same day (J28).	$64.70
G391A	Critical care, each further 15 min after G395A, or 4th+ physician Tick with G395A for each quarter hour after the first. 4th and later physicians on a life-threatening case bill G391A per 15 min instead of G521A–G523A (J26, J28).	$34.35
A644A	Also a brief assessment before the procedure Partial assessment. The only visit allowed before a planned Z-code procedure when you decided on it at an earlier visit (SP4 §13).	$24.50
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for day surgery or transfers within the hospital (GP42).	+30%
E083A	You're the MRP +30% on MRP subsequent visits. Not if the hospital pays you for in-patient work, unless reduced to match (GP47).	+30%
E409A	Procedure started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective. +50% of the procedures ticked below, not the visit (GP103–GP104).	+50%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the visit (GP103–GP104).	+75%
E409A	Started 17:00–24:00 weekday, or weekend/holiday day or evening Non-elective (or delayed by an emergency). +50% of this operation and any procedure ticked below (GP104).	+50%
E410A	Started at night, 00:00–07:00 Non-elective (or delayed by an emergency). +75% of this operation and any procedure ticked below (GP104).	+75%
E420A	Trauma patient with ISS over 15 (over 12 under age 16) +50% on this consult, assessment or operation and any procedure ticked, 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%
A645A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2).	$100.15
A645A	Emergency consult that led to this surgery Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).	$100.15
E638A	Transbronchial lung biopsy With or without image intensification (P9).	$81.90
E677A	TBNA of mediastinal or hilar nodes P9.	$104.00
E678A	TBNA of a lung mass P10.	$104.00
E636A	Broncho-alveolar lavage For malignancy or infection, with specimens for cell counts (P9).	$50.00
E632A	Removed a foreign body P9.	$68.40
E633A	Dilated a stricture P9.	$44.55
E635A	Palliative endobronchial tumour resection Including laser or cryotherapy (P9).	$67.20

E634A	Placed an endobronchial blocker or catheter P9.	$52.00
E846A	Rigid bronchoscopy right after the flexible one Only to treat what the flexible scope found (P9).	$95.70
E838A	High-risk patient in respiratory failure Severe hypoxaemia or hypercapnia. You stay until oxygen is back to baseline and ventilation isn't needed (P10).	$79.40
E622A	Patient under 3 years old Any bronchoscopic procedure (P9).	$79.40
E837A	Each additional EBUS biopsy Max 3 (P10).	$50.75
E696A	Dilated the oesophagus S7.	$30.65
E698A	Pneumatic or balloon dilation S7.	$69.70
E702A	3+ biopsies of one lesion S7.	$15.10
E690A	Removed a foreign body or stent S7.	$43.85
E813A	Radiofrequency ablation of dysplastic Barrett's To Z399A, Z515A or Z527A (S7).	$215.00
E683A	Done by VATS, robotic or uniportal approach +35% (P12–P13, P16, S9–S10).	+35%
E644A	Radical mediastinal node dissection after neoadjuvant therapy After preoperative chemotherapy and/or radiotherapy only (P16, S8).	$400.00
E616A	Right bi-lobectomy, or segmentectomy plus lobectomy same side P17.	$305.50
E619A	Sleeve lobectomy P17.	$162.45
E621A	With a diagnostic wedge resection P17.	$45.85
E608A	Each additional wedge resection Max 3 (P17).	$84.15
E618A	Decortication of remaining lobes or major lysis of adhesions, 60+ min 60+ minutes on this alone, start and end times charted, or not paid (P17).	$426.50
E607A	Re-operation 30+ days after a previous excision P17.	$152.30
E609A	Stump covered with intercostal muscle, pericardium, azygos vein or fat pad To M142A (P16).	$121.70
E612A	Total extra-pleural pneumonectomy P17.	$338.35
E613A	Sleeve pneumonectomy P17.	$500.00
E615A	Intra-pericardial dissection P17.	$250.00
E611A	Diaphragm resected, direct suture closure Mesh reconstruction: E849A instead (P17).	$145.00
E849A	Diaphragm resected, mesh reconstruction P17.	$220.00
E617A	Pleural tent P17.	$78.80
Z329A	Mediastinoscopy first, same anaesthetic Z329A at 85% of $380.00 as the second procedure (SP2 §3).	$323.00

Z327A	Bronchoscopy before the resection, same anaesthetic Z327A at 85% of $124.90 (SP2 §3). Not if you scoped this patient in the last 3 weeks, and never right after the resection (P9).	$106.17
E676A	BMI over 40, open operation under general anaesthetic +25%, once per patient. BMI charted. Not with thoracoscopy (SP6–SP7).	+25%
E793A	Laparoscopic or thoracoscopic (or assisted) +25% to S091A, S092A or S079A (S9).	+25%
E758A	Also repaired a hiatus hernia To S161A or S100A (S9).	$217.35
E744A	With gastroplasty S9.	$115.80
E742A	With cholecystectomy or vagotomy Each additional procedure. Any other combination: 85% rule (S9, SP2).	$217.35
E847A	Diaphragm reconstruction with mesh P12, S8–S9.	$75.00
E730A	With reconstruction To S090A (S8).	$740.95
E640A	Chest wall reconstruction with synthetic material Defect at least 5 cm after resection (P12).	$179.55
E601A	Each additional rib beyond 3 Max 3 more (P12).	$57.50
E602A	With sternal resection P12.	$177.95
E604A	Each rib fixed beyond four P12.	$55.60
K036A	Northern Health Travel Grant form Your part of the form for a patient travelling from Northern Ontario (A60).	$10.25
K070A	Home care referral form You're the most responsible physician sending the patient to home care (drains, wound care). Once per home care admission (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. Start and stop times charted. 1 a day (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 (A48–A49).	$16.45
K708A	Discussed at a cancer conference (MCC) today Pre-scheduled MCC to Ontario Health standards, you took part (chair: K709A, $47.75). Payable the same day as a visit (A29).	$37.05
K121A	In-patient case conference, per unit Pre-scheduled, with the MRP and 2+ others, 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months (A31–A33).	$37.05

Did a procedure?

Z341A	Chest tube inserted Tube thoracostomy for closed drainage (P14).	$76.80
Z332A + E542A	Thoracentesis, outside hospital Diagnostic or therapeutic (P14).	$117.05
Z332A	Thoracentesis, in hospital P14.	$104.40
Z363A	Chest tube removed Not the same day as insertion (P14).	$20.00
Z352A	Lytic agent through the chest tube Thrombolytic or fibrinolytic (P14).	$50.00
Z349A	Intrapleural chemotherapy or sclerosing agent Any method. Under GA with intercostal drainage: Z339A ($182.90) (P14).	$23.25
Z336A	Pleural needle biopsy Includes diagnostic aspiration (P14).	$59.15
Z340A	Lung needle biopsy P14.	$243.30
Z361A	Indwelling pleural catheter inserted Malignant effusion, palliative. Includes image guidance (P15).	$200.00
Z362A	Indwelling pleural catheter removed Adjusting one isn't Z362A: bill the visit (P15).	$200.00
Z359A	Repeat bronchoscopy for tracheobronchial toilet Within a week of another bronchoscopic procedure (P10).	$56.65
Z344A	Tracheo-bronchial aspiration First one; later ones Z345A ($18.60). Not to the operating surgeon, not in the first 2 h post-op (P11).	$45.95
Z326A	Tracheostomy tube changed P11.	$12.50
Z741A	Tracheotomy P11.	$273.15
Z325A	Emergency tracheotomy Life-threatening, patient not intubated. Percutaneous tracheostomy or cricothyroidotomy don't count (P11).	$474.65
Z101A + E542A	Wound abscess drained, local Outside hospital, with tray (M1).	$40.85
Z080A + E542A	Wound debridement into fat, one 10+ min, done by you, time charted. Not after your own surgery unless a complication needs more than usual care (M10).	$34.55

Can I bill these together?

Code	With	Together?	Why
G521A,G523A,G522A	G395A	No	G395A isn't paid with G521A, G522A or G523A the same day (J28).
G391A	G521A, G523A, G522A	No	G391A is either the 4th and later physicians' fee in place of G521A–G523A (J26), or the time after G395A, which isn't paid with G521A–G523A the same day (J28).
G521A,G523A,G522A	G211A, Z437A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters, drugs given, defibrillation and cardioversion are included in life-threatening critical care (J26).
G395A,G391A	G211A, G268A, G269A, Z611A, G380A, G356A, Z459A, G372A	No	Intubation, lines, cutdowns, blood gases, NG tube or lavage, catheters and drugs given are included in other critical care (J28).
G521A,G395A	A645A, A935A, A646A, A643A, A644A	Sometimes	A consultation or assessment before or after the critical care is paid; assessment and monitoring during it are not, and its time can't count twice (J27, J28).
E078A	A643A, A644A	No	E078A is only paid to the specialties listed in GP25; General Thoracic Surgery (64) isn't one of them (GP25).
A645A,A646A,A643A,A935A	Z341A, Z332A, Z336A, Z340A, Z361A, Z362A, Z327A, G050A, Z329A, Z330A, Z335A, Z399A	Sometimes	Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A644A) is payable before it that day (SP4 §13).
A644A	Z341A, Z332A, Z363A, Z336A, Z340A, Z361A, Z362A, Z327A, Z359A, Z329A, Z335A, Z399A, Z101A, Z080A	Yes	A partial assessment is allowed before a planned Z-code procedure (SP4 §13).
A645A,A935A,A646A,C645A,C935A,C646A	M142A, M143A, M144A, M145A, M149A, M151A, M135A, M137A, M106A, M105A, M116A, M132A, S091A, S079A, S090A, S089A, S096A, S161A	Yes	The consult where you decide to operate is the major pre-operative visit: never included in the surgical fee, whenever the surgery happens (SP2, GP4).
A643A,A644A,C643A,C644A	M142A, M143A, M144A, M145A, M149A, M151A, M135A, M106A, M105A, S091A, S079A, S090A, S089A	Sometimes	Only when this is the visit where you decided to operate. A hospital or day-surgery admission assessment that isn't that visit isn't paid (SP2).
Z363A	Z341A	No	Chest tube removal isn't paid the same day as the insertion (P14).
Z327A	Z292A, Z293A, Z515A	No	When bronchoscopy is done with a laryngoscopy or oesophagoscopy, only the bronchoscopy is paid (P9).
Z360A	Z327A, Z359A, Z342A, G050A	No	No other bronchoscopy service is paid with emergency rigid bronchoscopy Z360A (P9).
Z327A	M142A, M143A, M144A, M145A	Sometimes	Not paid right after your thoracic operation under the same anaesthetic, or on the day of a major lung resection if you scoped the patient in the 3 weeks before; otherwise paid at 85% under the same anaesthetic (P9, SP2 §3).
Z329A	M142A, M143A, M144A, M145A	Yes	Paid, but at 85% as the second procedure under the same anaesthetic; the resection is paid in full (SP2 §3).
E846A	Z327A	Sometimes	Only when the rigid scope treats a condition the flexible bronchoscopy just found (P9).
E837A	G050A	Yes	Up to 3 additional EBUS biopsies are paid on top of G050A (P10).
E683A	E676A	No	E676A needs an open technique for the thorax, and thoracoscopy is excluded; E683A means the case was done by VATS, robot or uniportal approach (SP6, P16).
E644A	M142A, M143A	Sometimes	Only after preoperative chemotherapy and/or radiotherapy; otherwise node dissection is part of the resection (P16).

Code	With	Together?	Why
E618A	M142A, M143A, M144A, M145A	Sometimes	Only with 60+ dedicated minutes and start/end times in the chart (P17).
M105A	Z353A, Z354A	No	Chest wall biopsies Z353A and Z354A aren't paid the same day as M105A (P12).
S086A	S088A	No	An open cricopharyngeal myotomy isn't paid with the diverticulum excision (S8).
Z505A	S086A	No	Endoscopic cricopharyngeal myotomy Z505A isn't paid with the open myotomy S086A (S8).
S091A	S161A, S100A	Sometimes	With a myotomy (S161A or S100A), S9 lists the hiatus hernia repair as the E758A add-on ($217.35), so bill E758A rather than S091A for that repair (S9).
E758A	S161A, S100A	Yes	E758A adds $217.35 for a hiatus hernia repair with the myotomy (S9).
E793A	S091A, S092A, S079A	Yes	+25% for a laparoscopic or thoracoscopic hiatus hernia repair (S9).
E409A	E410A	No	One after-hours premium per case, by the time the procedure started (GP104).
E420A	E409A, E410A	Yes	E420A isn't applied to the after-hours premium, but the after-hours premium is still payable (GP109).
K036A,K070A,K730A, K738A	A645A, A935A, A646A, A643A, A644A, C124A, C126A	Yes	Paid on top of the visit: K036A to the specialist too (A60); K070A with the assessment (A58); K730A and K738A with visits the same day (A42, A48).
K708A,K709A,K121A	A645A, A935A, A646A, A643A, A644A, C642A, C122A, C123A, C124A, C126A	Yes	Only services rendered during the conference are not paid; a visit outside it the same day is (A29, A32).
K708A	K709A	No	Only one of K708A, K709A, K710A or K711A per physician per day (A29).
C122A	C124A, C126A, C642A	No	One subsequent visit a day, and C122A/C123A aren't paid the same day as C124A or C126A (GP43–GP44).
C142A,C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (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	C648A	No	E083A is only for the MRP's own subsequent visits (GP47).
E083A	C642A, C647A, C649A, C122A, C124A, C982A	Yes	E083A applies to the MRP's subsequent visits, C121A–C126A, C142A, C143A and C982A (GP47).
E084A	C642A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; General Thoracic Surgery (64) isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026); pages in brackets. Totals are your fee only (suffix A): the surgical assistant bills the Asst units × $12.91 and the anaesthetist the Anae units × $15.96, plus time units, with suffix B or C (GP85, GP92). Totals leave out the 85% rule for a second procedure under the same anaesthetic (SP2 §3) unless you tick it, and any procedure entered outside the procedure list. Age premiums for patients under 16 on consults and surgery are added by OHIP on the remittance (GP64).

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