Vascular Surgery OHIP Billing Cheat Sheet 2026

OHIP specialty 17 · Aortic aneurysm · Carotid & leg bypass · Angioplasty & endovascular · Updated November 2026
Interactive version: https://verismo-apex.com/resources/ohip-billing-cheatsheet/vascular-surgery

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

Office consultation

A175A	Consultation Written referral from a physician or NP; written report back. Limit: 1 per patient per 2 years for the same diagnosis (GP17).	$125.15
A935A	Long consultation, 50+ minutes Special surgical consultation: every part of a consult plus 50+ minutes face to face, not counting procedures or chart and imaging review (GP19–GP20).	$194.65
A176A	Repeat consultation Same problem, new written referral, after another physician cared for the patient in between (GP19).	$66.60

- 50+ minutes face to face? A935A pays $194.65, $69.50 more than A175A. Time spent on procedures or reading imaging doesn'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).
- Varicose vein surgery is only insured with reflux on Doppler or duplex, 3+ months of failed analgesics and prescription compression stockings, and a listed sign or complication. Chart all three now (Q19).
- 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).

Office follow-up

A174A	Follow-up or post-op visit History of the problem, the exam needed, advice. Partial assessment.	$26.75
A173A	Full work-up of one problem Full history of the complaint and detailed exam of the affected system. Specific assessment. Limit: 1 per patient per 12 months (2 if a clearly different diagnosis), then paid as a lesser fee (GP23).	$49.30

- Ankle-arm index: G517A ($10.05). A full study (4+ segmental pressures, PVRs or Doppler tracings on a device with hard-copy output) is J200; not both (J19, G9).
- Outside a hospital only the professional part of a duplex or vascular lab study is billable, with suffix C (G1–G2).
- Post-op office visits are billable: the surgical fee only covers care until the first post-op visit (SP1). After an amputation, limb-fitting supervision and 6 months of post-op care are billed as visits (N1).
- Debriding an ulcer you decided to treat at an earlier visit? Only A174A can go before it that day (SP4 §13). Sclerotherapy G536A includes one post-injection visit (J55).
- E078A (chronic disease premium) isn't payable to vascular surgery (17): GP25 lists the specialties that can bill it, and 17 isn't one.

Aortic aneurysm

R802A	Open abdominal aortic repair, tube graft or endarterectomy One surgeon (Q14).	$2,031.95
R817A	Open repair including iliac and/or femoral arteries One or both sides (Q14).	$2,655.20
R875A	EVAR (endovascular stent graft) Includes all catheters and reading the images taken during it (Q13).	$1,563.05
R888A	EVAR, two surgeons: you're the first Second surgeon bills R889A ($1,172.30), no assistant or anaesthesia units (Q13).	$1,172.30
R896A	Open repair, two surgeons: you're the first Tube graft or endarterectomy. Second surgeon R897A ($1,523.95). Iliac/femoral extension: R886A/R887A ($1,991.40 each) (Q14–Q15).	$1,523.95
R803A	Thoraco-abdominal aneurysm Two surgeons: R898A/R899A, $2,446.40 each (Q14).	$3,261.85

- Two surgeons together earn more: open repair $1,523.95 each ($3,047.90) against $2,031.95 for one; EVAR $1,172.30 each ($2,344.60) against $1,563.05 (Q13–Q14).
- Ruptured: E627A +$619.25. Called in: bill the ED consult with its premiums from the Called to ED tile, plus E409A or E410A if the operation started 17:00–07:00 or on a weekend or holiday (SP2 §2, GP104).
- Branched or fenestrated graft: E510A +$926.85; not for branches to the common iliac and not with E627A (Q13). Conduit: E509A +$805.65.
- Open repair: IMA reimplanted E626A +$174.35; suprarenal or supraceliac clamp E986A +$250.00 (Q15).

- BMI over 40: E676A +25% with R802A, R817A and R803A, not with EVAR (SP6). A second assistant needs no prior approval for R802A, R803A or R817A (GP90).

Carotid & leg bypass

R792A	Carotid endarterectomy With or without bypass graft. Patch: E665A below (Q13).	$982.95
R791A	Fem-pop bypass, vein With or without endarterectomy (Q17).	$1,077.25
R794A	Fem-pop bypass, prosthetic Q17.	$733.15
R787A	Fem-tibial or peroneal bypass, saphenous or arm vein With or without splicing (Q17).	$1,265.00
R780A	Fem-tibial or peroneal bypass, prosthetic Q17.	$878.00
R804A	In situ saphenous vein bypass, tibial One surgeon. Popliteal: R797A ($1,414.15) (Q18).	$1,643.00
R933A	Axillo-femoral, fem-fem or axillo-axillary graft Axillo-bifemoral R932A ($1,200.00) (Q16).	$656.55
R813A	Embolectomy, artery or graft, sole procedure Thrombectomy as sole procedure: R867A ($490.00) (Q17).	$769.55

- Your own vein pays more: fem-pop R791A $1,077.25 vs prosthetic R794A $733.15; fem-distal R787A $1,265.00 vs R780A $878.00 (Q17).
- Carotid patch: E665A +$419.00. R815A isn't payable with R792A (Q13).
- Two vascular surgeons on an in situ tibial bypass: R766A + R767A, $1,303.00 each, instead of R804A. Only for specialty 03 or 17 (Q18).
- E649A (embolectomy/thrombectomy with another vascular procedure) pays only at another site, or at the main site when clot was there before surgery (Q11–Q12).
- Arterial repairs include endarterectomy, thrombectomy, bypass graft and graft harvest unless the listing says otherwise (Q1). Fees are one side; a second procedure under the same anaesthetic is 85% (SP2 §3, SP4 §9).

Angioplasty & endovascular

J025	Angioplasty, anatomy already known One or more sites or vessels; includes angiography and pressure measurements (E2).	$610.10
R878A	Subintimal recanalization, femoral, popliteal or tibial Includes catheters, angiography and all image guidance (Q17).	$759.60
R879A	Subintimal recanalization, iliac or aorta Includes catheters, angiography and all image guidance (Q17).	$759.60
J021	Diagnostic angiogram by catheter Abdominal, thoracic, cervical or cranial. Catheter insertion (cut-down if needed) and injection. Selective vessels: J022 below (E2).	$186.05
J027	Peripheral arteriogram, direct puncture Venogram by direct puncture: J026 ($108.55) (E3).	$76.55
J056	Catheter-directed thrombolysis Transcatheter fibrinolytic therapy (E2).	$1,027.95

- Anatomy known: J025 includes the angiography, so no J021/J022. Anatomy unknown at the time: J021 and/or J022 at 50% with it (E2).
- Both sides punctured and dilated at once: the second angioplasty is paid at 50% (E2).
- R878A/R879A cover catheters, angiography and imaging; no one bills the images. Not the same day as R809A, R791A, R794A, R787A, R780A or R797A (R878A), or R860A/R861A (R879A). Both sides are separate services only through separate incisions (Q17).
- Radiology fees for the imaging may be claimed in addition to these J procedures (E1). Non-elective after hours: E409A/E410A apply to J001–J068 (GP104).

Varicose veins

R868A	High ligation and stripping, long saphenous With groin dissection (Q19).	$200.00
R869A	Stripping, short saphenous With popliteal dissection (Q19).	$107.50
R837A	Multiple ligation and avulsion Q19.	$200.00
R844A	Recurrent varicose veins Multiple ligation and/or stripping (Q19).	$353.80
R842A	Incompetent perforators, full fascial technique Plus stripping: E653A below (Q19).	$384.75
Z745A	Saphenous ligation Q19.	$53.20

- Long or short saphenous surgery is insured only with all three: junction reflux on Doppler or duplex, 3+ months of failed conservative care (analgesics and prescription gradient stockings), and a listed sign (eczema, pigmentation, lipodermatosclerosis, ulcer) or complication (Q19).
- Fees are one leg. Other procedures under the same anaesthetic, including the other leg, pay 85% (SP2 §3, SP4 §9). Z745A is a Z-code: both sides are paid in full (SP4 §13).
- Sclerotherapy: G536A ($77.85) per side, including one post-injection visit; repeat sessions G537A ($26.05). Only veins over 5 mm with symptoms, injected by you; no imaging fees for guidance (J55).
- Cosmetic vein treatment isn't insured (SP5 §16).

Dialysis access

R827A	AV fistula created J37, Q21.	$490.15
R946A	Brachio-basilic fistula transposition Includes venography, image guidance and any revision or re-anastomosis (J38).	$975.50
R851A	Dialysis graft, synthetic Autogenous vein graft: R840A ($496.60) (J37).	$482.70
R941A	Open thrombectomy of fistula or graft J38.	$350.00
R943A	Revision by plication, imbrication or resection Both arterial and venous sides, with or without thrombectomy (J38).	$400.00
R944A	Revision by angioplasty, patch, graft or segment replacement With or without thrombectomy (J38).	$650.00
R945A	Fistula aneurysm resected or repaired With or without thrombectomy (J38).	$975.50
Z464A	Declotted by cannula Any method; includes contrast, drugs and image guidance. No image fees to anyone (J38).	$150.00

- Only one of R941A, R942A, R943A, R944A, R945A or R946A per patient per day, any physician: pick the one that pays most for what you did (J38).
- Patch or graft revision R944A pays $650.00, $250.00 more than plication R943A (J38).
- R825A/R826A (AV aneurysm or fistula resection) aren't for dialysis access; use R945A (Q21).
- Ligation of a dialysis fistula is R942A ($250.00); not the same day as R841A or R833A (J38).
- Dialysis catheters are below: tunnelled G099A ($168.40), temporary G324A ($102.95) (J37).

Amputation

R624A	Below knee Tibia/fibula (N50).	$552.70
R626A	Above knee Through femur (N41).	$602.80
R630A	Hip disarticulation N36.	$753.50
R623A	Symes Terminal Symes R619A ($144.80) (N52).	$285.80
R622A	Transmetatarsal or transtarsal N52.	$326.60
R621A	Ray, single N52.	$286.00
R620A	Toe (metatarsal or phalanx disarticulation) Each more: E585A below (N52).	$226.00

- Immediate prosthetic fitting, including supervision of the final fitting: E586A adds 40% (N1).
- Limb-fitting supervision and 6 months of post-op care are billed as visit fees (N1).
- Each additional toe at the same time: E585A +$47.30 (N52).
- Both legs or a second procedure under the same anaesthetic: 85% (SP2 §3). Debridement isn't billed after your own surgery unless a complication needs more than usual post-op care (M10).

Called to ED or ward

A175A	Consultation Requested by the ED or ward physician. Written report.	$125.15
A935A	Long consultation, 50+ minutes 50+ minutes face to face, excluding procedures (GP19).	$194.65
A176A	Repeat consultation Same problem, new request, after another physician's care in between.	$66.60
A173A	Full work-up, your own patient Specific assessment.	$49.30
A174A	Brief assessment Partial assessment.	$26.75

- Called in non-electively: bill A-prefix codes plus the special visit premiums, not C-codes (GP43, GP65).
- The premiums shown are the ED table (I). For a ward in-patient (table III) or out-patient clinic (table II) the amounts are the same; bill that table's codes (GP71–GP72).
- Weekday daytime emergency surgery: consult + special visit premium + operation. Evenings, nights, weekends: add E409A or E410A to the operation (SP2 §2).
- Admitting the patient as MRP? E082A adds 30% to this consult, once per admission (GP42).
- Took the patient to the OR? Pick the operation's tile and tick the consult there (SP2 §2).

In-patient consult

C175A	Consultation Requested by the attending physician, routine (not a called-in visit).	$125.15
C935A	Long consultation, 50+ minutes 50+ minutes face to face (GP19).	$194.65
C176A	Repeat consultation	$66.60
C173A	Full work-up Specific assessment.	$49.30
C174A	Re-assessment Specific re-assessment. 2 per 12 months except admissions (GP23).	$28.80
C178A	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

- Called in urgently instead? Use the ED or ward tile for A-codes and premiums (GP43).
- Your admission assessment for surgery is only payable when it's the visit where you decided to operate (SP2, GP40).
- A surgeon brought into the case on consultation who then operates or assists may also claim the consult, justified on an IC basis (SP3 §8).

- G517A and J198 aren't payable during surgery or the patient's post-op stay (J19, G7).

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, not just monitoring, and you didn't give that care. One of C122A or C142A per admission (GP46).	$71.80
C143A	Second visit after transfer out of ICU, you're the MRP Same conditions. One of C123A or C143A per admission (GP46).	$71.80
C172A	Routine daily visit 1 a day in weeks 1–5; then C177A (3 a week) and C179A (6 a month) (GP43).	$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; the limits don't apply to it (GP43).	$40.05

- As MRP, C122A and C123A pay $71.80 instead of $31.00 for the first two days after admission (GP44).
- E083A adds 30% to your MRP visits. The E084A weekend premium isn't open to vascular surgery (17) (GP47).
- Visit limits run from the admission date if you admitted the patient, or from the referral date if they were referred to you in hospital (SP2).
- Long-term care: W175A consult; chronic care hospital W172A (first 4 a month) then W171A (6 more); nursing home W173A (first 2) then W178A (3 more); W121A for intercurrent illness; W124A on discharge ($40.05–$71.80) (A209, GP49).
- 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
K036A	Northern Health Travel Grant form Your part of the form for a patient travelling from Northern Ontario. Paid to the referring physician and the specialist (A60).	$10.25
K070A	Home care referral form You're the MRP sending the patient to Ontario Health atHome (wound care, IV). Paid on top of the visit. Once per home care admission; not if already on home care (A58–A59).	$34.75
K730A	Phoned another physician for advice 10+ min, you keep caring for the patient, both in Ontario. Not to arrange a referral, transfer or test, or mainly to discuss results. Start and stop times charted. 1 a day. Paid on top of the visit (A42–A43).	$37.05
K738A	Sent an e-consult to another physician Secure server, opinion back within 30 days. 1 a day, 6 per patient per 12 months. Paid on top of the visit (A48–A49).	$16.45
K121A	In-patient case conference, per unit Pre-scheduled, with the MRP and 2+ others, 10+ min. Units: 1 = 10 min, 2 = 16, 3 = 26, then +10. Max 4 per patient per 12 months. Your visit outside the conference is still paid (A31–A33).	$37.05
G517A	Ankle-arm index Ankle pressures with the ankle-arm ratio. Not during surgery or the post-op stay; not with J200 (J19).	$10.05
J200C	Ankle pressure study, read by you 4+ segmental pressures, PVRs or Doppler recordings, hard-copy output. Professional part (G9).	$21.40
J196C	With exercise or quantitative measurements Add-on to J200, professional part (G9).	$10.10
J202C	Peripheral arterial or venous duplex, per limb, read by you Professional part. Below the inguinal ligament or axilla; one of J193/J202 per limb per day. Technical part only in hospital (G1–G2, G7).	$16.60
J201C	Carotid duplex, read by you Bilateral carotid, subclavian and/or vertebral. Professional part. One of J190/J201 per day (G7).	$24.65
E082A	You admitted the patient and are the MRP This consult is your admission assessment. Once per admission; not for day surgery; not if the hospital pays you for in-patient work (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 consult (GP103–GP104).	+50%
E410A	Procedure started at night, 00:00–07:00 Non-elective. +75% of the procedures ticked below, not the consult (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 the procedural fees; shown here on the main 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 the procedural fees; shown here on the main operation and any procedure ticked below (GP104).	+75%
E420A	Trauma patient with ISS over 15 (over 12 under age 16) +50% 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%
A175A	Decided to operate at a consult today The major pre-op visit is paid on top of the surgery (SP2).	$125.15
A175A	Consult that led to this emergency operation Special visit premiums go with this consult; add them from the Called to ED tile (SP2 §2).	$125.15
A173A	Assessed your own patient before the operation Specific assessment (SP2 §2).	$49.30
E627A	Ruptured aneurysm To R802A, R896A, R817A, R886A, R875A, R888A, R803A or R898A (Q13, Q15).	$619.25
E510A	Branched or fenestrated device To R875A or R888A. Not for branches to the common iliac; not with E627A (Q13).	$926.85
E509A	Conduit to the aorta or common iliac To R875A or R888A (Q13).	$805.65
E626A	Inferior mesenteric artery reimplanted To R802A, R896A, R817A or R886A (Q15).	$174.35
E986A	Suprarenal or supraceliac clamp To R802A, R896A, R817A or R886A (Q15).	$250.00
E649A	Embolectomy or thrombectomy too Only at a site other than the main operation, or at the main site when clot was there before surgery (Q11–Q12).	$112.45
E655A	Redo for a failed graft Repair or replacement of the existing prosthesis, more than one month after the first operation (Q2).	$348.70
E676A	BMI over 40, general anaesthetic +25%, once per patient. BMI charted. Only with the codes listed on SP6: R802A, R817A, R803A, R933A here (SP6–SP7).	+25%
E665A	Closed with a patch To R792A (Q13).	$419.00
E672A	Composite graft (vein plus prosthetic) Listed with the vein bypasses R791A and R787A (Q17).	$133.40
E679A	Vein harvested away from the bypass site Only when the saphenous vein is unavailable (Q11).	$124.10
J058	Stent placed Vascular stenting (E2).	$101.55
J022	Each selective vessel Per vessel, max 4. Not with J025 when anatomy is known (E2).	$92.15
E815A	Angioplasty away from the dissection site Includes any stents or devices (Q17).	$398.15
J025	Other side too, same session Simultaneous bilateral punctures and angioplasties: the second at 50% (E2).	+50%
R837A	Also avulsions, same leg (85%) R837A at 85% of $200.00 under the same anaesthetic (SP2 §3).	$170.00
R869A	Also stripped the short saphenous (85%) R869A at 85% of $107.50 (SP2 §3).	$91.38
E653A	Plus stripping With perforator surgery R842A (Q19).	$127.15
R868A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%

R869A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R837A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R844A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R842A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R624A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R626A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R622A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R621A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
R623A	Other side too (bilateral) Same procedure on the other side at 85% (SP2 §3).	+85%
Z745A	Other side too (bilateral) Z-code: both sides paid in full (SP4 §13).	+100%
E585A	Each additional toe N52.	$47.30
E586A	Immediate prosthetic fitting +40%, includes supervision of the final limb fitting (N1).	+40%

Did a procedure?

G536A	Sclerotherapy, one leg Veins over 5 mm with symptoms, by you. Includes multiple injections, bandaging and one post-injection visit (J55).	$77.85
G537A	Repeat sclerotherapy, one leg J55.	$26.05
Z080A + E542A	Ulcer or wound debridement into fat, one 10+ min, by you, time charted per lesion. Two Z081A, three Z082A, four+ Z083A. In hospital, drop E542A ($12.65) (M10).	$34.55
Z081A + E542A	Debridement into fat, two M10.	$45.55
Z083A + E542A	Debridement into fat, four or more M10.	$78.40
Z084A + E542A	Debridement into tendon, ligament or bone, one Two or more: Z085A ($98.65) (M10).	$78.40
Z085A + E542A	Debridement into tendon or bone, two or more M10.	$111.30
R873A	Thrombin injection, femoral pseudoaneurysm Duplex guidance J202 is payable with it (Q16).	$68.20
G099A	Tunnelled dialysis catheter, percutaneous Jugular or femoral (J37).	$168.40
G324A	Temporary dialysis catheter, subclavian or jugular Revision G336A ($17.65); femoral G327A ($77.30) (J37).	$102.95
Z456A	Implantable central venous catheter Subcutaneous reservoir: Z446A ($168.00) (J7).	$296.50
Z457A	Tunnelled central line removed or repaired, surgically J7.	$60.00
G268A	Arterial line J7.	$31.25
R838A	IVC filter, transvenous Q20.	$330.65

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	A175A, A935A, A176A, A173A, A174A	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).
A175A,A935A,A176A, C175A,C935A,C176A	R802A, R817A, R875A, R888A, R896A, R803A, R792A, R791A, R794A, R787A, R780A, R804A, R933A, R813A, R878A, R879A, R868A, R869A, R837A, R844A, R842A, R827A, R946A, R851A, R944A, R624A, R626A, R622A, R621A, R620A	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).
A173A,A174A,C173A, C174A	R802A, R817A, R875A, R792A, R791A, R794A, R787A, R780A, R868A, R837A, R827A, R624A, R626A	Sometimes	Only when this is the visit where you decided to operate. A hospital admission assessment that isn't that visit isn't paid (SP2).
A174A	Z080A, Z081A, Z082A, Z083A, Z084A, Z085A, Z745A, Z464A	Yes	A partial assessment is allowed before a planned Z-code procedure, and is paid with it when it's the visit where you decided on it (SP4 §13).
A175A,A173A,A176A	Z080A, Z081A, Z082A, Z083A, Z084A, Z085A, Z745A	Sometimes	Only when this visit is where you decided on the procedure. If you decided in the last 12 months, only a partial assessment (A174A) is payable before it that day (SP4 §13).
A935A	A175A	No	A935A is the consultation itself, billed instead of A175A when you spend 50+ minutes face to face (GP19–GP20).
R815A	R792A	No	R815A isn't payable with R792A; a patch is E665A (Q13).
E665A	R792A	Yes	Patch graft add-on to carotid endarterectomy (Q13).
E510A	E627A	No	E510A isn't paid with E627A (Q13).
E510A,E509A	R875A, R888A	Yes	Listed add-ons to R875A or R888A (Q13).
E627A	R802A, R896A, R817A, R886A, R875A, R888A, R803A, R898A	Yes	Ruptured aneurysm add-on to these codes (Q13, Q15).
E626A,E986A	R802A, R896A, R817A, R886A	Yes	Listed add-ons to open abdominal aortic repair (Q15).
R875A,R888A	J021, J022	No	EVAR includes all catheters, access catheters too, and reading the images taken during it (Q13).
R766A,R767A	R804A	No	R766A and R767A aren't paid with R804A (Q18).
R878A	R809A, R791A, R794A, R787A, R780A, R797A	No	R878A isn't paid the same patient, same day as these (Q17).

Code	With	Together?	Why
R879A	R860A, R861A	No	R879A isn't paid the same patient, same day as R860A or R861A (Q17).
E815A	R878A, R879A	Yes	Remote angioplasty add-on to subintimal recanalization (Q17).
J025	J021, J022	Sometimes	Not when the anatomy is already known; when it isn't, J021 and/or J022 are paid at 50% (E2).
J058	J025	Yes	Stenting is listed separately from angioplasty (E2).
G517A	J200	No	G517A isn't paid with J200 (J19, G9).
J190	J201	No	Only one of J190 or J201 per patient per day (G7).
J193	J202	Sometimes	Only one of J193 or J202 per extremity per patient per day; another limb is fine (G7).
G536A,G537A	J202, J193	Sometimes	Not when the scan is done to guide the injections: imaging for guidance isn't payable with sclerotherapy (J55).
R873A	J202	Yes	J202 is payable with R873A (Q16).
R941A	R942A, R943A, R944A, R945A, R946A	No	Only one of R941A–R946A per patient per day, any physician (J38).
R942A	R943A, R944A, R945A, R946A, R841A, R833A	No	One of R941A–R946A per day, and R942A isn't paid the same day as R841A or R833A (J38).
R943A	R944A, R945A, R946A	No	Only one of R941A–R946A per patient per day, any physician (J38).
R944A	R945A, R946A	No	Only one of R941A–R946A per patient per day, any physician (J38).
R945A	R946A	No	Only one of R941A–R946A per patient per day, any physician (J38).
Z080A,Z081A,Z082A, Z083A,Z084A,Z085A	Z154A, Z175A, Z176A, Z177A, Z179A, Z190A, Z191A	No	Laceration repair isn't paid with wound or ulcer debridement (M10).
Z402A	R802A, R817A, R792A, R791A, R794A, R787A, R780A, R933A	No	Arteriotomy isn't allowed with other major cardiovascular surgery (Q11).
E649A	R802A, R817A, R792A, R791A, R794A, R787A, R780A, R933A	Sometimes	Only at a site other than the main operation, or at the main site when clot was present before surgery (Q11–Q12).
E676A	R802A, R817A, R803A, R933A, R855A	Yes	On the SP6 list: +25% for BMI over 40 under general anaesthetic, BMI charted (SP6–SP7).
E676A	R875A, R888A, R792A, R791A, R787A	No	E676A is only payable with the procedures listed on SP6; these aren't (SP6).
E586A	R624A, R626A, R630A, R623A, R622A	Yes	+40% to the amputation fee for immediate prosthetic fitting (N1).
E585A	R620A	Yes	Each additional toe adds to R620A (N52).
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).
E078A	A173A, A174A	No	E078A is only paid to the specialties listed in GP25; Vascular Surgery (17) isn't one of them (GP25).
K036A,K070A,K730A, K738A	A175A, A935A, A176A, A173A, A174A, 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).
C122A	C124A, C126A, C172A	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).

Code	With	Together?	Why
E083A	C178A	No	E083A is only for the MRP's own subsequent visits (GP47).
E084A	C172A, C122A, C123A, C124A	No	E084A is only for MRPs in the specialties listed on GP47; Vascular Surgery isn't one.

Fees and rules from the Ontario Schedule of Benefits (July 1, 2026): Vascular Surgery A208–A209, Cardiovascular Surgical Procedures Q1–Q21, dialysis access J37–J38, sclerotherapy J55, angiography procedures E1–E3, vascular ultrasound G7–G9, amputations N1 and N52, the Surgical Preamble and the General Preamble; 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). A second procedure under the same anaesthetic is paid at 85% (SP2 §3): options marked 85% or bilateral show that amount; other ticked procedures show their full fee. Percentage premiums (E409A, E410A, E420A, E586A, E676A) are shown on the main operation and ticked procedures only; OHIP applies them to every eligible procedural fee. Vascular lab and duplex fees are the professional part (suffix C); the technical part is paid only in a hospital (G1–G2). Age premiums for patients under 16 on consults and surgery (+10% to +30%) 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.