



Quick Billing Tips: Genetics

July 2026

The full definitions, payment rules and medical record requirements of the services described in this guide are detailed in the OHIP Schedule of Benefits.

Disclaimer:

Every effort has been made to ensure that the contents of this document is accurate. Members should, however be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable. Regulations with the Government of Ontario including but not limited to the Ministry of Health (MOH) and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing = by contacting their regional OHIP office.

[OHIP Schedule of Benefits \(Effective April 1, 2026\)](#)

TIME UNITS

# Units	Minimum Time with Patient
1 unit	20 minutes
2 units	46 minutes
3 units	76 minutes [1h 16m]
4 units	106 minutes [1h 46m]
5 units	136 minutes [2h 16m]
6 units	166 minutes [2h 46m]
7 units	196 minutes [3h 16m]
8 units	226 minutes [3h 46m]

Important requirement for all time-based codes:

Start and stop times (not duration, but actual start and stop times) must be recorded in the patient's medical record.



OUT-PATIENT

Title	Code	Amount	Payment Notes
A consultation is an assessment rendered following a written request from a referring physician or nurse practitioner. A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician or nurse practitioner. Where the referral is made by a nurse practitioner, the consultant shall provide the report to the nurse practitioner and the patient's primary care provider, if applicable.			
Consultation	A225	\$190.50	
Special genetic consultation	A220	\$342.25	Spends a minimum of 75 minutes in direct contact with the patient with or without family
Extended special genetic consultation	A223	\$442.40	Spends a minimum of 90 minutes in direct contact with the patient with or without family
Genetic Minor Assessment	A221	\$38.05	
Genetic care	K222	\$90.55	- Time-based service for a genetic assessment that is payable Per Unit Limit: Max 4 units per patient, per day - Calculated based on the duration of direct contact between the physician and the patient or family.
Complex genetic test interpretation	K229	\$65.85	- Per unit Limit: Max 2 units per patient, per, 12-month period - Time based and based on duration time spent exclusively interpreting the complex genetic tests. - Interpretation includes interpretation done for any genetic testing where the laboratory report does not clearly explain the patient's phenotype or requires additional review to understand the implications of the result. - Needs to be attached to A code or K222
Clinical interpretation	K223	\$42.10	- Not eligible for payment when rendered in association with a consultation on the same patient. - Must submit findings, opinions, and recommendations in writing to the referring physician. You do not have to see the patient.

Genetic family counselling	K044	\$62.75	• Per Unit • Time based • Counselling dedicated to educational dialogue between MD and 1+ fam members or patient rep. patient does not need to be present. • Bill under genetic patient number. • There is no stated maximum number of units. However, if billing more than 8 units, you must submit the claim manually and include supporting documentation to support the services provided.
Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act	K002	\$80.00	• Per unit • Only eligible for payment if the physician can demonstrate that the purpose of the interview is not for the sole purpose of obtaining consent. • Bill under patient number
Detention	K001	\$21.10	• Time based • Must document start and stop times. • Used when need to spend extra time beyond maximum A/C code billing in active treatment mgt and/or monitoring of the patient at the exclusion of other work) • Special visit premiums can be claimed with the assessment/ consultation codes K001 is claimed with. There are no additional premiums added to K001.
Other			
Northern Health Travel Grant Application Form completion	K036	\$10.25	
Skin Biopsy(ies), any method, when sutures are not used	Z113	\$32.45	

IN-PATIENT

Title	Code	Amount	When to use
New In-patient Consult			
Consultation	C225	\$190.50	
Special genetic consultation	C220	\$342.25	Spends a minimum of 75 minutes in direct contact with the patient with or without family
Extended special genetic consultation	C223	\$442.40	Spends a minimum of 90 minutes in direct contact with the patient with or without family
Subsequent Visits	C222	\$40.05	- Per visit - First five weeks
	C227	\$40.05	- Per visit - Sixth to thirteenth week inclusive - Limit: maximum 3 per patient per week
	C229	\$40.05	- Per visit - After thirteenth week - Limit: maximum 6 per patient per month
Genetic care, patient or family	K222	\$90.55	- Per Unit - Limit: 4 unit per patient per day - Time unit based on time in direct contact with patient/family. - Time based
Other critical care			
first ¼ hour (or part thereof)	G395	\$64.70	- Calculated based on duration spent in direct contact with patient. - Time based. Time can be non-consecutive - G395 is not eligible for payment with G521, G522 or G523 for services rendered to the same patient by the same physician on the same day - During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients. - Can use travel/after hour premiums if appropriate
after first ¼ hour per ¼ hour (or part thereof)	G391	\$34.35	

Special Visit Premium



A special visit is a visit that requires the physician to assess a patient:

- In response to a request initiated by the patient or a person caring for the patient (non-elective visit); or
- On a physician-initiated visit to a patient's home (elective visit) provided the patient's home is not a Long-Term Care facility, including a nursing home or home for the aged.

Assessments are eligible when:

- Assessment rendered in patient's home (elective or non-elective service)
- Assessment rendered in any other location (non-elective only)

Comprises of: Travel premium and First person or additional person seen

Claims for an assessment rendered in conjunction with a special visit premium are to be submitted using the appropriate A-prefix assessment fee from the "General Listings" (with some exception, such as K023 Palliative care support), regardless of the location or type of facility to which the special visit applies.

- If the assessment is a C225, submit as A225 + SVP
- If the assessment is K023 or G521, submit as is + SVP

Not eligible for payment when:

- For patients seen during rounds at a hospital or long-term care institution (including a nursing home or home for the aged).
- In conjunction with admission assessments of patients who have been admitted to hospital on an elective basis.
- For services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients.
- For a visit for which critical care team fees are payable under the Schedule.
- For services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours, even if held at night or on weekends or holidays.
- For visits in the emergency room where the "H" prefix assessment codes may be payable.

Example of how to bill:

Assessment + Special Visit Premium + Travel Premium

Emergency Department

Not eligible for payment to Emergency Department Physicians (see definition GP67)

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	\$37.40 K960 (max 2 per time period)	\$37.40 K961 (max 2 per time period)	\$37.40 K962 (max 2 per time period)	\$37.40 K963 (max 2 per time period)	\$37.40 K964 (max 2 per time period)
First Person seen	\$20.55 K990 (max 10 (total of first and additional person seen) per time period)	\$41.10 K992 (max 10 (total of first and additional person seen) per time period)	\$61.70 K994 (max 10 (total of first and additional person seen) per time period)	\$77.10 K998 (max 20 (total of first and additional person seen) per time period)	\$102.80 K996 (no max. per time period)
Additional Person(s) seen	\$20.55 K991 (max 10 (total of first and additional person seen) per time period)	\$41.10 K993 (max 10 (total of first and additional person seen) per time period)	\$61.70 K995 (max 10 (total of first and additional person seen) per time period)	\$77.10 K999 (max 20 (total of first and additional person seen) per time period)	\$102.80 K997 (no max. per time period)

Hospital In-Patient

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	\$37.40 C960 (max 2 per time period)	\$37.40 C961 (max 2 per time period)	\$37.40 C962 (max 2 per time period)	\$37.40 C963 (max 2 per time period)	\$37.40 C964 (max 2 per time period)
First Person seen	\$20.55 C990 (max 10 (total of first and additional person seen) per time period)	\$41.10 C992 (max 10 (total of first and additional person seen) per time period)	\$61.70 C994 (max 10 (total of first and additional person seen) per time period)	\$77.10 C986 (max 20 (total of first and additional person seen) per time period)	\$102.80 C996 (no max. per time period)
Additional Person(s) seen	\$20.55 C991 (max 10 (total of first and additional person seen) per time period)	\$41.10 C993 (max 10 (total of first and additional person seen) per time period)	\$61.70 C995 (max 10 (total of first and additional person seen) per time period)	\$77.10 C987 (max 20 (total of first and additional person seen) per time period)	\$102.80 C997 (no max. per time period)

If the in-patient is in the ICU or CCU

ADD C101: Intensive Care or Coronary Care Unit premium \$9.10

Hospital Out-Patient (e.g. medical day unit)

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	\$37.40 U960 (max 2 per time period)	\$37.40 U961 (max 2 per time period)	\$37.40 U962 (max 2 per time period)	\$37.40 U963 (max 2 per time period)	\$37.40 U964 (max 2 per time period)
First Person seen	\$20.55 U990 (max 10 (total of first and additional person seen) per time period)	\$41.10 U992 (max 10 (total of first and additional person seen) per time period)	\$61.70 U994 (max 10 (total of first and additional person seen) per time period)	\$77.10 U986 (max 20 (total of first and additional person seen) per time period)	\$102.80 U996 (no max. per time period)
Additional Person(s) seen	\$20.55 U991 (max 10 (total of first and additional person seen) per time period)	\$41.10 U993 (max 10 (total of first and additional person seen) per time period)	\$61.70 U995 (max 10 (total of first and additional person seen) per time period)	\$77.10 U987 (max 20 (total of first and additional person seen) per time period)	\$102.80 U997 (no max. per time period)

Consultation with Another Physician

Title	Code	Amount	When to use
Telephone Consultation (Physician to physician) - All services rendered by the consultant physician to provide opinion/ advice/recommendations on patient care, treatment and management to the referring physician. The consultant physician is required to review all relevant data provided by the referring physician or nurse practitioner. - Minimum of 10 minutes of patient-related discussions. - Both referring and consultant physicians must be in Ontario at the time of service. - Must include start and stop times. - Name of referring and consulting physician. - Reason for consultation and the recommendations of the consultant physician. Not eligible when: - Discussion is to arrange transfer of patient care. - When arranging for a consultation - When rendered primarily to discuss results of diagnostic investigations or - When a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician-to-physician telephone consultation for the same patient.			
Consultant Physician	K731	\$47.75	Limit: 1 payment per patient per day
Referring Physician	K730	\$37.05	Limit: 1 payment per patient per day
Physician on duty in an emergency department or a hospital urgent care clinic			
Consultant Physician	K735	\$47.75	Physician on duty in an emergency dept or urgent care clinic Limit: 1 payment per patient per day
Referring Physician	K734	\$37.05	Physician on duty in an emergency dept or urgent care clinic Limit: 1 payment per patient per day
PHYSICIAN/NURSE PRACTITIONER TO PHYSICIAN E-CONSULTATION			
Referring physician	K738	\$16.45	Eligible for payment when the call is to collect additional data to support specialist re-assessment.
Consultant physician	K739	\$20.50	

Medical record requirements:

1. Patient's name and health number
2. Name of the referring physician/ nurse practitioner and consultant physician
3. Reason for the consult and
4. The opinion and recommendations of the consultant physician.



Case Conference Codes



- Must include participation by the physician most responsible for the care of the patient and at least 2 other eligible participants specified are present.
- Time based services calculated in 10-minute increments.
- **Medical Record Requirements:** A single medical record in the patient's chart for the case conference, signed or initialed by all participating physicians.
- **Not eligible for payment** for educational purposes such as rounds, continuing professional development, or any meeting where the conference is not for the purpose of discussing and directing the management of an individual patient.

Limits:

- A maximum of 4 services per patient, per physician, per 12-month period.
- A maximum of 8 units are payable per physician, per patient, per day.
- Not eligible if supervision of postgraduate medical trainees.

Case Conferences for hospital patients

Code	Eligible Participant	Eligible Patient	Amount
K121	• Physicians • Regulated social workers • Regulated health professionals	Hospital inpatient in an acute care, chronic care or rehabilitation hospital	\$37.05 per unit
K124	• Physicians • Regulated social workers • Regulated health professionals • Employee of a Ontario Health atHome	Long-term care institution in patient or Ontario Health atHome	\$37.05 per unit

Counselling of relatives-on behalf of catastrophically or terminally ill patient



- K015 - \$80.00 per unit
- For developing an awareness of modalities for treatment of the patient and/or his or her prognosis)
- Submit under patient

Additional Resources

- [OHIP Schedule of Benefits, April 1, 2026](#)
- [OHIP Claims Submission Process](#) (including manual review and stale dated claims)
- [OMA Billing Resources including delegated services, special premiums etc.](#)
- [OHIP Info Bulletins](#)
- [Education and Prevention Committee Billing Briefs](#)
- For more information email: info@oma.org

