

Quick Billing Tips: Infectious Disease

July 2026

Agenda

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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 April 1, 2026](#)

Special Visit Premium & Travel Codes

A visit initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service or, if rendered in the patient's home, a non-elective or elective service. SVP are only eligible for payment for certain services listed in the Schedule of Benefits.

Claims submission instructions:

Submit claims using the appropriate A-prefix assessment fee from the “General Listings” for an assessment rendered in conjunction with a special visit premium.

Special Visit Premium Table: Emergency Department

Not eligible for payment to Emergency Department Physicians

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with sacrifice of office hours	Evenings (17:00-24:00) Monday – 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. 10 (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. 10 (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)

SVP cannot be claimed for:

- 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 non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C989);
- 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 this Schedule;
- in conjunction with any sleep study service listed in the sleep studies section of this Schedule; or
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

Assessment & Consultation Codes

Required Elements of a Consultation:

- Must have a written referral from physician or nurse practitioner.
- Must prepare a written report (including findings, opinions and recommendations) to the referring physician and/or NP or the amount payable for the service will be adjusted to a lesser assessment fee.
- Is required to perform a general, specific or medical specific assessment, including a review of all relevant data (e.g. history, physical findings and relevant test results and reports)
- Start and stop times must be recorded

Title	Code	Amount	Notes
Consultation	A465	\$205.90	
Comprehensive infectious disease consultation	A460	\$342.25	Provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient. The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.
Limited consultation	A275	\$119.30	
Repeat consultation	A466	\$124.00	
Medical Specific Assessment	A/C463	\$107.00	Must be a direct physical patient encounter Limit: 1 per 12-month period unless, • The patient returns within 12 months with an unrelated complaint and a clearly different diagnosis from the first assessment. - or • At least 90 days since last specific assessment and the 2nd assessment is a hospital admission Not applicable for visit to patient's house.
Complex Medical Specific Re-Assessment	A/C461	\$95.05	Any <i>combo of</i> medical specific assessments and complex medical specific reassessments are limited to 4 per patient per physician per 12-month period
Medical Specific Re-Assessment	A/C464	\$82.10	Max of 2 per 12-month period unless rendered for a hospital admission.
Partial Assessment	A468	\$62.15	No limit

Common Infectious Disease Codes

Title	Code	Amount	Notes
Critical Care Codes	The service rendered when a physician provides critical care to a critically ill or critically injured patient. Critical care is defined as acutely impairs one or more vital organ system(s) causing vital organ system failure as a result of which imminent life-threatening deterioration in the patient's condition is highly probable.		
Life Threatening Critical Care (Code Blue)	G521	\$125.10	Not eligible if you are MRP First ¼ hour (or part thereof)
	G523	\$64.50	Second ¼ hour (or part thereof)
	G522	\$42.50	After first ½ hour, per ¼ hour (or part thereof)
Other Critical Care	G395	\$64.70	First ¼ hour (or part thereof) Per physician per patient for the first three physicians
	G391	\$34.35	after first ¼ hour per ¼ hour (or part thereof)
Comprehensive care (Intensive care area) For: Physician-in-charge	G557	\$429.30	1 st day
	G558	\$256.25	2nd to 30th day, inclusive, per diem
	G559	\$122.80	31st day onwards, per diem
Critical Care (Intensive Care area) For: Physician-in-charge	G400	\$223.10	1 st day
	G401	\$146.45	2nd to 30th day, inclusive
	G402	\$58.60	31st day onwards
In-patient Codes			
Subsequent Visits	C462	\$40.05 per visit	First 5 weeks
	C467		6-13 th week inclusive, maximum 3 per patient per week
	C469		More than 13 weeks, maximum 6 per patient per month
Subsequent Visits by MRP	C122	\$71.80	Day following the hospital admission assessment
	C123		Second day following the hospital assessment
	C124		Day of discharge
	C126	\$95.10	Day of discharge, medically complex patient (see A13 for terms and conditions)
Subsequent Visits by MRP following transfer from ICU	C142	\$71.80	1st subsequent visit by the MRP following transfer from an Intensive Care Area
	C143		2nd subsequent visit by the MRP following transfer from an Intensive Care Area

	C121	\$40.05	Additional visits due to intercurrent illness
ICU/CCU	C101	\$9.10 per patient seen	Payable alone when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by surgeon).
Outpatient Billing			
Chronic disease assessment	E078	Add 50% premium on certain conditions	• Can be added on to any of the non-consult codes. • Only can be used in an outpatient setting • Must use a diagnostic code from a pre-approved list (Page GP25) Common ones are: HIV (code 044), DM (250), Cirrhosis (571)
Other			
Home care application	K070	\$34.75	• Initial submission and completion of an application form for homecare • Limited to one per home care admission per patient. • Not eligible if patient is currently receiving home care
Acute home care supervision	K071	\$21.95	For providing medical advice or information to CCAC such as changes to antibiotics, PICC removal, wound care request, communication Limited to: • Maximum of one service per patient per physician per week for 8 weeks following admission to the home care program • Maximum of two services per patient per week for 8 weeks • Maximum of four services per patient per month
Hospital in-patient case conference	K121	\$37.05 per unit	• Not eligible for payment for a resident in a long-term care institution • Limited to a maximum of 4 services per patient, per physician, per 12-month period • Maximum of 8 units of K121 are payable per physician, per patient, per day • Not eligible for supervision of postgraduate medical trainees



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 to be eligible for payment.

Physician to Physician Telephone Consultation

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 consulting 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.			
Referring Physician	K730	\$37.05	Limit: 1 payment per patient per day
Consulting Physician	K731	\$47.75	Limit: 1 payment per patient per day
Physician on duty in an emergency department or a hospital urgent care clinic			
Referring Physician	K734	\$37.05	Limit: 1 payment per patient per day
Consulting Physician	K735	\$47.75	Limit: 1 payment per patient per day

Resources

- [Scheule of Benefits – Effective April 1, 2026](#)
- [OMA Billing Resources](#)
- [Special Visit Premium Guide](#)
- [Assessments and Consultations](#)
- [Case Conference Services Guide](#)
- For more information, email info@oma.org