

Dermatology OHIP Billing Cheat Sheet 2026

OHIP specialty 02 · Procedure or light therapy only · E-assessment or phone advice · Office consultation · Updated October 2026

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

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

Office consultation

A025A	Consultation Written, signed referral on the chart; written report back to the referrer (GP16). Limit: 1 per 24 months for the same diagnosis.	\$77.50
A021A	Advanced consultation Complex systemic disease with skin signs (lupus, sarcoid, dermatomyositis, scleroderma, blistering disease, vasculitis, cutaneous lymphoma, pyoderma or Sweet's with IBD, porphyria, paraneoplastic), prurigo nodularis, DRESS / EM major / TEN, or psoriasis or dermatitis with BSA over 30%, on systemic therapy, or 30+ min face to face. Limit: Counts toward the consult limit.	\$164.90
A026A	Repeat consultation Same problem, new written referral, after another doctor cared for the patient in between (GP19).	\$47.75

- Psoriasis or eczema on methotrexate, a biologic or other systemic therapy, or over 30% BSA: bill A021A (\$164.90), more than double A025A (A92).
- For psoriasis or dermatitis, A021A by time needs 30+ min face to face, not counting procedures, chart review or notes. Write the start and stop times (A92, GP7).
- One consult per patient per 24 months for the same diagnosis; a clearly unrelated diagnosis allows one every 12 months. Extra consults are paid as A023A (GP17).
- Biopsy or excision at the consult where you decided to do it: the consult is paid on top of the procedure (SP2, SP4).
- No written referral on the chart, or the referral was asked for after the visit: OHIP pays it as an assessment (GP16).

Office follow-up

A020A	Complex dermatology assessment Ongoing care of an A021A-type condition, psoriasis or dermatitis on systemic therapy, over 30% BSA or 15+ min face to face, or skin cancer risk: melanoma T1b+, morpheic BCC, SCC stage 2+, 10+ actinic keratoses, multiple dysplastic nevi, or a neoplasm of uncertain behaviour with pathology on file. Must include every element of a specific assessment. Limit: 6 per patient per 12 months.	\$60.00
A023A	Specific assessment Full history of the complaint and detailed exam of the affected areas. Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$46.15
A024A	Partial assessment History of the complaint, the exam needed, advice. Routine follow-up and post-op checks.	\$23.50

- A020A pays \$60.00, more than 2.5 times A024A (\$23.50). High-risk skin cancer follow-ups (10+ AKs, multiple dysplastic nevi, melanoma T1b+) qualify (A93–A94).
- A020A is 6 per patient per 12 months; extras are paid as a lesser assessment, so save them for the visits that need the full exam (A94).
- A023A is 1 per patient per 12 months (2 when a clearly different, unrelated diagnosis is made); more are cut to A024A (GP23).
- Booked Z procedure (biopsy, cryo, benign excision) planned at an earlier visit: only A024A can be billed before it that day (SP4).
- Pre-booked R excision (skin cancer, pre-malignant): the pre-op check that day is part of the surgical fee. Bill an assessment only for a separate, unrelated problem (SP1, SP4).
- E078A (chronic disease premium) isn't payable to dermatology (02): GP25 limits it to geriatrics, endocrinology, neurology, paediatrics, pathology, physical medicine, radiation oncology, medical oncology, infectious disease, respirology, rheumatology, haematology and clinical immunology, so OHIP won't pay it.

Procedure or light therapy only

- Light therapy alone: G470A + G700A = \$16.65. G700A is added once per visit when a + procedure (G470A, G375A, G377A) is the only reason (J3).
- G470A is 1 per patient per day and pays \$0 in a hospital in-patient or out-patient department. Staff can deliver it under your supervision (J36, GP62).
- Z codes booked from an earlier visit: a partial assessment (A024A) before the procedure is still payable (SP4).
- Excision codes count lesions per visit and site: two malignant lesions on the face = R049A (\$152.50), not R048A twice.
- The tray fee E542A (\$12.65) is paid only outside hospital and only on codes that list it: Z116A yes, Z113A no; curettage of skin cancer (R018A–R033A), Z117A and Z119A no (M1–M7).

Video or phone

A024A + K300A	Video follow-up, patient you know Paid at 100%. A023A + K300A for a specific assessment.	\$23.50
A024A + K301A	Phone follow-up, patient you know OHIP pays 85% (\$19.98).	\$23.50
A020A + K301A	Complex dermatology follow-up by phone Same conditions as in office. OHIP pays 85% (\$51.00); by video A020A + K300A pays 100%.	\$60.00
A025A + K300A	Consultation by video Video only, never phone.	\$77.50
A021A + K300A	Advanced consultation by video Same criteria as in the office (A92). Video only, never phone (Appendix J).	\$164.90
A101A	Video, no prior relationship Limited virtual care.	\$20.00
A102A	Phone, no prior relationship Limited virtual care.	\$15.00

- Consultations (A025A, A021A, A026A) are video only. A020A, A023A and A024A can be video or phone (Appendix J, AJ1).
- Phone pays 85% of the in-person fee; video pays 100%. Bill the full fee: OHIP reduces it (A70).
- If the rash or lesion needs an in-person exam after all, bill only the in-person visit (A67).
- Existing relationship = an in-person service by you in the last 24 months, or a video consult by you; otherwise A101A or A102A (A66).

E-assessment or phone advice

U025A	Initial e-assessment First e-assessment by you for this patient and diagnosis; written opinion back. Limit: 1 per 12 months (2 if a new diagnosis).	\$47.75
U023A	Repeat e-assessment First one after your initial e-assessment or consult, same diagnosis.	\$31.15
U026A	Follow-up e-assessment Limited follow-up for a patient you have already served for this diagnosis. Limit: 1 a day, 4 per patient per 12 months.	\$23.50
U021A	Minor e-assessment Short answer to one specific question (dosing, next step). Limit: 1 a day, 12 per patient per 12 months.	\$11.80
K731A	A doctor or NP phoned you for advice 10+ min of patient discussion, start and stop times charted, their billing number on the claim. Not to arrange a visit, transfer or test, or mainly to go over results (A42–A44). Limit: 1 per patient per day; \$0 if you see the patient that day or the next.	\$47.75

- Answer within 30 days of the request and put the requester's billing number on the claim (GP35–GP36).
- Not payable when the e-assessment is used to arrange a visit, procedure or transfer of care (GP35).
- Seeing the patient for the same diagnosis within 60 days of the request: that visit pays only A023A or A024A, not a consult (GP35).
- Chart needs the patient's name and health number, the requester, the date and reason, and your opinion (GP36).
- A family doctor phoned instead: K731A pays \$47.75 for 10+ minutes, \$0 if you see the patient that day or the next. The K739A e-consult code isn't paid to dermatology; use the U codes (A43, A49).

Called to ED

A027A	Consultation Referred patient seen on a special visit to the emergency department.	\$158.15
A023A	Specific assessment Patient you already know, full exam of the problem.	\$46.15
A024A	Partial assessment Brief look and advice.	\$23.50

- A027A (\$158.15) is the consult for a special visit to ED, in-patient or LTC: more than double A025A. Bill it with the K (ED), C (in-patient) or W (LTC) special visit premium (A91).
- Special visit premiums need the time of the visit in the chart (GP69).
- In hospital, drop E542A from procedure codes: the tray fee is paid only outside hospital (M1).

Hospital in-patient consult

C025A	Consultation, routine Non-emergency in-patient consult.	\$158.15
A027A	Consultation, called in Non-elective special visit to a ward patient; add the C special visit premiums.	\$158.15
C026A	Repeat consultation Same problem, new request, after another doctor's care in between.	\$47.75
C020A	Complex dermatology assessment Same conditions as A020A. Limit: 6 per 12 months.	\$60.00
C023A	Specific assessment	\$46.15
C024A	Specific re-assessment	\$27.25
C028A	Concurrent care Family doctor stays MRP and asked you to keep directing care. Limit: 4 in week 1, then 2 a week.	\$40.05

- Routine ward consults pay the same as A027A; only a non-elective call-in adds the special visit premiums (GP65, GP72).
- Concurrent care is 4 claims in the first week and 2 a week after; extra claims pay \$0, and E083A/E084A never apply to it (GP47–GP48).
- Your own admitted patient day to day? Use the Hospital rounds tile.

Hospital rounds

C022A	Subsequent visit 1 a day in weeks 1–5. Weeks 6–13: C027A (3 a week); after week 13: C029A (6 a month) (GP43).	\$40.05
C122A	Day after admission, you're the MRP Once per admission; not the same day as C124A/C126A (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
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. Instead of C124A (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 \$40.05 for the first two days after admission (GP44).
- As MRP add E083A (+30%) to every subsequent visit, or E084A (+45%) on Saturdays, Sundays and holidays; dermatology (02) qualifies for both. One per patient per day (GP47).
- Patient came to your ward from the ICU? C142A and C143A replace C122A/C123A; not if you gave the critical care (GP46).
- Palliative patient you're MRP for: C982A (\$40.05) per visit; E083A/E084A apply to it (GP47, GP50).

Also bill, if it's true

E409A	Non-elective surgery started 17:00–24:00 weekdays, or 07:00–24:00 weekend or holiday Adds 50% to the procedure fee(s). Non-elective, or an elective case pushed into that time by an emergency. Not for an ED physician on shift (E412A instead) (GP103–GP104, SP2).	+50%
E410A	Non-elective surgery started 00:00–07:00 Adds 75% to the procedure fee(s). Same conditions as E409A (GP104, SP2).	+75%
G372A	Injection with the visit Each intramuscular, subcutaneous or intradermal injection (e.g. first biologic dose).	\$4.55
G373A	Injection was the only reason for the visit First injection; each extra one is G372A (\$4.55).	\$7.90
K001A	Detention, per 15 minutes Only after the visit's own time is used up: 60 min for A025A, A023A, A020A; 90 min for A021A; 30 min for A024A. Chart start and stop times (GP29–GP31).	\$21.10
G700A	The procedure was the only reason for the visit Once per visit, with + procedures only (G470A, G375A, G377A). Not in hospital, not with an assessment.	\$8.80
E083A	I'm the MRP, weekday +30% on MRP subsequent visits, C121A–C143A and C982A. One of E083A/E084A per patient per day. Not if the hospital pays you for in-patient work (GP47).	+30%
E084A	I'm the MRP, Saturday, Sunday or holiday +45% instead of E083A (GP47).	+45%
K730A	Phoned another doctor for advice, 10+ min You keep caring for the patient. Not to arrange a referral, visit or test, or mainly to discuss results. Paid on top of the visit (A42–A43).	\$37.05
K738A	Sent an e-consult Paid once the other doctor answers within 30 days. Max 1 a day and 6 per patient per 12 months. Paid on top of the visit (A48).	\$16.45
K036A	Filled in a Northern Health Travel Grant form Payable to the specialist as well as the referring doctor (A60).	\$10.25
A024A	Also did a partial assessment Before a Z procedure booked at an earlier visit, a partial assessment is the only visit fee allowed (SP4).	\$23.50

Did a procedure?

Z113A	Punch or shave biopsy, no stitches Any number of biopsies, any method. No tray fee.	\$32.45
Z116A + E542A	Biopsy closed with stitches Pays \$12.65 more than Z113A outside hospital. A second lesion is IC only (M1).	\$45.10
Z117A	Liquid nitrogen or chemical, 1+ lesions Includes paring. 1 per patient per day (M7).	\$12.75
Z119A	Liquid nitrogen to 5+ actinic keratoses Liquid nitrogen only; diagnostic code 232 (M5).	\$31.80
R160A + E542A	Pre-malignant excision, face or neck, 1 lesion AK, dysplastic nevus, leukoplakia and other listed lesions; pathology report on file. 2 lesions R161A, 3+ R162A (M5).	\$70.95
R163A + E542A	Pre-malignant excision, other areas, 1 lesion 2 lesions R164A, 3+ R165A (M5).	\$60.40
R048A + E542A	Skin cancer excision, face or neck, 1 lesion Pathology report on file or paid as a lesser fee (M6).	\$113.60
R049A + E542A	Skin cancer excision, face or neck, 2 lesions	\$165.15
R050A + E542A	Skin cancer excision, face or neck, 3+ lesions	\$267.90
R094A + E542A	Skin cancer excision, other areas, 1 lesion BCC, SCC, in-situ lesions (lentigo maligna, Bowen's).	\$76.35
R040A + E542A	Skin cancer excision, other areas, 2 lesions	\$117.50
R041A + E542A	Skin cancer excision, other areas, 3+ lesions	\$222.35
R018A	Skin cancer curettage, cautery or cryosurgery, face or neck, 1 lesion 2 lesions R019A (\$123.70), 3+ R020A (\$247.30). No tray fee (M6).	\$75.10
R031A	Skin cancer curettage, cautery or cryosurgery, other areas, 1 lesion 2 lesions R032A (\$99.45), 3+ R033A (\$199.05) (M7).	\$60.35
R010A	Melanoma wide excision Margins over 1 cm and layered closure (M6).	\$135.95
R081A	Mohs surgery, first stage Mohs-trained, you read your own slides. Once per lesion; 2nd lesion same day 85% (M8–M9).	\$315.45
E524A	Mohs, one or more extra stages Once per lesion, with R081A (M8).	\$273.45
Z156A + E542A	Benign lesion (keratosis, pyogenic granuloma) excised and sutured Not cosmetic. 2 lesions Z157A, 3+ Z158A (M3).	\$34.55
Z159A	Benign lesion removed by curette or cautery Complete removal, not paring. 2 lesions Z160A, 3+ Z161A. No tray fee (M3).	\$11.55
Z162A + E542A	Nevus excised and sutured Clinical suspicion, not cosmetic. 2 lesions Z163A, 3+ Z164A (M3).	\$34.55
Z122A + E542A	Cyst, haemangioma or lipoma, face or neck Local. 2 lesions Z123A, 3+ Z124A (M4).	\$54.85
Z125A + E542A	Cyst, haemangioma or lipoma, other areas Local. 2 lesions Z126A, 3+ Z127A (M4).	\$47.70
G375A	Intralesional injection, 1 or 2 lesions Not for acne (J54).	\$10.50
G377A	Intralesional injection, 3+ lesions Not for acne (J54).	\$15.80
G396A	Injections of extensive keloids Keloids off the head or neck: only if symptomatic, with prior approval (AD2).	\$24.90
G470A	UV light or PUVA session 1 a day; \$0 in hospital (J36).	\$7.85

G012A	KOH or wet mount read in your office Wet preparation for fungus or parasites. Chart the result, your reading and the treatment decision (J65, J68).	\$1.93
G206A	Patch test, per allergen Up to 90 per patient per year; occupational: G198A, up to 125 (J4).	\$2.39
Z101A + E542A	Incision and drainage of an abscess or cyst Local anaesthetic, one. Two: Z173A (\$33.25); 3+: Z174A (\$44.70) (M1).	\$40.85
Z080A + E542A	Wound or ulcer debridement into fat, one 10+ min, done by you, time charted. Two Z081A (\$32.90), three Z082A (\$49.30), 4+ Z083A (\$65.75); into tendon or bone Z084A (\$65.75), two or more Z085A (\$98.65). Includes the dressing (M10).	\$34.55

Can I bill these together?

Code	With	Together ?	Why
E078A	A020A, A023A, A024A	No	E078A is only paid to the specialties listed in GP25; Dermatology (02) isn't one of them (GP25).
A025A,A021A,A026A,A023A,A020A	Z113A, Z116A, Z117A, Z119A, Z156A, Z159A, Z162A, Z122A, Z125A, Z101A	Sometimes	Paid when this is the visit where you decided to do the procedure, or it's for an unrelated problem in another body system. If you decided at an earlier visit in the last 12 months, only a partial assessment (A024A) is payable before the Z procedure (SP4).
A024A	Z113A, Z116A, Z117A, Z119A, Z156A, Z159A, Z162A, Z122A, Z125A, Z101A	Yes	A partial assessment is payable before a Z procedure, even one booked at an earlier visit (SP4).
A025A,A021A,A026A,A023A,A020A,A024A	R048A, R049A, R050A, R094A, R040A, R041A, R018A, R031A, R160A, R163A, R010A, R081A	Sometimes	Paid when this is the visit where you decided to excise: the surgical fee never includes that visit (SP2). On a pre-booked excision day the pre-op check is part of the surgical fee unless you treat an unrelated problem (SP1, SP4).
G700A	A025A, A021A, A026A, A023A, A020A, A024A, A027A, U025A	No	G700A is only for a visit where a + procedure was the sole reason; not with a consult or assessment (J3).
G373A	A025A, A021A, A026A, A023A, A020A, A024A, A027A	No	G373A is for an injection that was the only reason for the visit. With an assessment, bill G372A (J54).
G373A	G700A	No	G373A already pays the sole-reason injection visit; G700A goes with + procedures only (J3, J54).
G700A	G470A, G375A, G377A	Yes	These are + procedures: add G700A once when they were the only reason for the visit (J3, J36, J54).
Z116A	Z117A	Yes	A biopsy with stitches may be paid with chemical or cryo treatment of a lesion (M1).
Z117A	Z117A	No	Z117A is limited to 1 per patient per day, however many lesions you treat (M7).
G470A	G470A	No	UV therapy is limited to 1 per patient per day (J36).
G375A	G377A	No	Count every lesion injected at the visit: 1–2 lesions is G375A, 3 or more is G377A (J54).
R081A	R048A, R049A, R050A, R094A, R040A, R041A	Sometimes	Only for different lesions. If a pathologist reads the Mohs slides, R081A and E524A aren't payable; bill the excision code instead (M8).
E524A	R081A	Yes	E524A is the add-on for one or more extra Mohs stages, once per lesion (M8–M9).
R048A,R094A,R160A,R163A,Z162A,Z122A,Z125A,Z156A	R011A, R002A, R045A, R072A	No	When the excision is closed with an advancement flap (undermining over 2.5 cm a side), rotation, transposition, Z-plasty or graft, bill the flap code instead of the excision (M6, M17).
Z080A,Z081A,Z082A,Z083A,Z084A,Z085A	Z176A, Z154A, Z175A, Z177A, Z187A, Z188A	No	Wound or ulcer debridement isn't payable with a laceration repair (M10).
C122A,C123A,C142A,C143A	C124A, C126A	No	C122A, C123A, C142A and C143A aren't paid the same day as the discharge visit C124A or C126A (GP44, 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	E084A	No	Only one of E083A or E084A per patient per day (GP47).
E083A,E084A	C028A	No	E083A/E084A are only for the MRP's own subsequent visits, not concurrent care (GP47).

Code	With	Together ?	Why
U025A	A025A, A021A	Sometimes	A consult for the same diagnosis within 60 days of the e-assessment request is paid only as a specific or partial assessment (GP35).
K731A	A025A, A021A, A026A, A023A, A020A, A024A, A027A, C025A, C026A, C020A, C023A, C024A, K001A	No	Phone advice pays \$0 when you see the patient for a consultation, assessment, visit or K-prefix time-based service the same day or the next (A43).
K730A, K738A	A025A, A021A, A026A, A023A, A020A, A024A, C022A, C122A, C124A	Yes	The referring doctor's phone or e-consult is paid in addition to visits the same day (A42, A48).
A021A	A025A	No	Only one consultation or assessment is paid per visit: bill A021A when the advanced criteria are met, otherwise A025A (GP10, A92).
A020A	A023A, A024A	No	Only one assessment is paid per visit: bill A020A when the complex criteria are met, otherwise A023A or A024A (GP10, A94).

Fees and rules from the Ontario Schedule of Benefits, July 1 2026 (pages in brackets). The tray fee E542A is included in procedure totals; drop it in hospital. Age premiums on consultations and surgery for children under 16 (GP64), special visit premiums and phone virtual reductions are applied by OHIP and aren't all shown here. Cosmetic removal of lesions, acne procedures and most warts are uninsured (Appendix D).

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