

Endocrinology & Metabolism OHIP Billing Cheat Sheet 2026

OHIP specialty 15 · Yearly diabetes fee · Insulin dose changes · Counselling or family interview · Updated October 2026

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

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

Office consultation

A155A	Consultation Written referral on file, full consult, written report back to the referring doctor (GP16).	\$172.95
A150A	Comprehensive consultation, 75+ min All consult elements plus 75+ minutes face to face, not counting procedures or chart and imaging review. Start and stop times in the chart (A98).	\$342.25
A255A	Limited consultation Referred for a narrower question that needs substantially less time than a full consult (GP19).	\$110.15
A156A	Repeat consultation Same problem, new written referral, and another doctor treated the patient since your first consult (GP19).	\$110.15

- 75+ minutes face to face? A150A pays \$342.25, almost double A155A (\$172.95). Chart start and stop times or it is cut to a lesser fee (A98).
- Even a limited (A255A) or repeat (A156A) consult at \$110.15 pays more than a medical specific assessment (\$95.95). Use one whenever there is a new written referral (GP19).
- One consult per patient per diagnosis per 2 consecutive 12-month periods. A second for the same problem is only paid as an in-patient or ED consult 12–24 months after the first, or as a repeat consult; a clearly unrelated diagnosis allows one per 12 months (GP17).
- No written, signed referral in the chart, or the referral was requested after the visit: OHIP pays it as an assessment (GP16).
- Thyroid FNA decided at this visit? Bill the consult and Z771A together. If the FNA was already planned at an earlier visit, only a partial assessment (A158A) is payable before it that day (SP4).

Follow-up visit

A154A	Medical specific re-assessment Full relevant history and exam of one or more systems. Limit: 2 per patient per 12 months (GP23).	\$72.00
A151A	Complex re-assessment Complex, obscure or serious condition. Written findings must go to the family doctor (GP24). Limit: 4 per 12 months, combined with A153A (GP24).	\$83.40
A153A	Medical specific assessment Full history of the complaint and detailed exam of the affected systems; new problem, no referral. Limit: 1 per 12 months (2 for a clearly different diagnosis) (GP23).	\$95.95
A760A	Complex endocrine neoplasm assessment Ongoing management of a thyroid, parathyroid, pituitary or adrenal neoplasm. Must include re-assessment elements; not for uncomplicated disorders (A98). Limit: 6 per 12 months, 12 per 24 months (A98).	\$102.95
A158A	Partial assessment History of the complaint, the exam needed, advice, record. No yearly limit.	\$44.75

- Diabetes (dx 250) or another listed chronic disease: tick E078A for +50%. A154A becomes \$108.00, A151A \$125.10, A153A \$143.93 (GP25–26).
- E078A is only for office or hospital out-patient clinic visits, not ED, in-patients or LTC, and never with A760A (GP25, A98).
- Over a limit, OHIP cuts the visit to a lesser fee: A154A 2 per 12 months, A153A 1 per 12 months, and A153A + A151A together 4 per 12 months (GP23–24). Past those, bill A158A (+ E078A) rather than have it reduced.
- A760A pays \$102.95 but takes no E078A. For a neoplasm patient who also has diabetes, A151A + E078A (\$125.10) pays more when the visit was mainly about the diabetes (dx 250) (A98, GP26).
- Each visit with a diabetes patient counts toward the 4 visits needed for the yearly K045A / K046A fees (A99).
- Reported a driver to the Ministry of Transportation (e.g. severe hypoglycaemia)? K035A \$36.25 is paid on top of the visit (A59).

Yearly diabetes fee

K045A	Diabetes management by a specialist You are most responsible for this patient's diabetes, 4+ consults, assessments, K013A, K033A, K029A, K002A or K003A with them in the 12 months, 100+ diabetes patients a year, and the flow sheet covers every CDA element (A99). Limit: 1 per patient per 12 months.	\$80.25
K045A + K046A	Plus diabetes team management Also have a Certified Diabetes Educator you employ on the team, with their services documented (A100–A101). Limit: 1 each per 12 months.	\$207.45

- K046A (\$127.20) is paid on top of K045A (A101). Together they add \$207.45 a year per patient.
- K046A is not payable when the CDE is employed by a hospital, public health unit, FHT, LTC home or anyone other than you (A101).
- Bill both only once the full 12 months of elements are done: A1C, lipids, ACR, eGFR (K046A), BP, weight and BMI, meds, vaccines offered, self-management support, eye referral, foot and neuro exam (A99–A100).
- Video and phone follow-ups count toward the 4 required visits (A75).

Insulin dose changes

G500A	Insulin started, or your first assessment of an insulin patient Month insulin (2+ injections a day or pump) was started, or the month you first assessed a patient already on it; 1+ contacts. Limit: 2 per patient per lifetime (J42).	\$31.80
G514A	Later month, 1 to 3 contacts Each contact = advice by phone or otherwise that changes the insulin dose or frequency.	\$10.60
G520A	Later month, 4 or more contacts If G514A and G520A are both claimed in a month, OHIP pays G520A only (J43).	\$21.20

- Only one of G500A, G514A, G520A per patient per month, and only for the doctor most responsible for the diabetes (or their substitute) (J42).
- A contact on the same day as a consult or assessment doesn't count. Reviewing logs or results with no dose change doesn't count either (J42).
- Keep a dated note of each contact. Your staff may pass on your decision; you must make it (J42–J43).

Counselling or family interview

K013A	Counselling or education Booked visit only for education and advice (diet, insulin, pump, weight). First 3 units per patient per 12 months.	\$80.00
K033A	Counselling, after the first 3 units this year Same service once K013A is used up for this patient.	\$56.30
K002A	Interview with relatives or substitute decision-maker Separately booked 20+ minutes about the patient's care, not just consent; billed on the patient's health number (GP61).	\$80.00

- Any specialty may bill counselling and interviews (GP9). 20 minutes of K013A pays \$80.00, more than an A154A (\$72.00).
- Counselling must be pre-booked and is not paid with a consult or assessment the same day. Injections, blood draws, interviews, the MTO report (K035A) and the LTC form (K038A) are allowed with it; tests and the home care form (K070A) aren't (GP58).
- Units: 20 min = 1, 46 = 2, 76 = 3. Chart start and stop times (GP55, GP7).
- K013A, K033A and K002A visits count toward the 4 needed for K045A and K046A (A99, A100).

Test or injection only

- The patient came only for a test or procedure marked + (ACTH, TRH/LHRH, glucagon, insulin tolerance, clonidine, water deprivation, saline, IV GTT, pentagastrin, phentolamine, implant, blood draw, IV): add G700A (\$8.80) once per visit, whatever the number of tests (J3).
- No G700A in a hospital, or when you also bill a consult or assessment that day (J3).
- Indirect calorimetry (G515A), the growth hormone exercise test (G358A) and thyroid FNA (Z771A) aren't marked +, so they take no G700A (J41, J43).
- An injection alone is G373A (\$7.90, first injection, then G372A for each extra one); G700A isn't added to it (J54).

Hospital in-patient consult

C155A	Consultation, routine request Seen on your own schedule.	\$172.95
C150A	Comprehensive consultation, 75+ min Same conditions as A150A: 75+ minutes face to face, start and stop times charted (A102).	\$342.25
C255A	Limited consultation Narrower question, substantially less time.	\$110.15
C156A	Repeat consultation Same problem, new request, another doctor treated in between.	\$110.15
A155A	Called in urgently to see another doctor's patient Non-elective call. Bill the A code; the in-patient special visit premiums apply (GP43, GP69).	\$172.95

- Urgent call to the ward: bill A155A, not C155A, and add the special visit premiums for the time of day. Chart the time of the visit (GP43, GP69).
- If you admit the patient as most responsible physician, this consult is your admission assessment: add E082A (+30%), once per admission (GP40, GP42).
- Seen in ICU or CCU? Add C101A (\$9.10) per patient, unless critical care team fees are claimed (GP103).
- A second consult for the same problem is allowed for an in-patient 12–24 months after the first (GP17).

Emergency department consult

A155A	Consultation Requested by the ED physician; report copy back to them.	\$172.95
A150A	Comprehensive consultation, 75+ min Start and stop times charted (A98).	\$342.25
A153A	Medical specific assessment Your own patient, or no consult request.	\$95.95
A154A	Medical specific re-assessment Patient you saw recently for the same problem.	\$72.00

- Called in from outside the hospital: travel plus first-person premiums apply. Evenings, weekends and nights pay more (GP66, GP70).
- Admitting them under you? The ED consult is your admission assessment; add E082A (+30%) (GP40, GP42).
- No E078A in the ED (GP25).

Hospital follow-up (rounds)

C152A	Subsequent visit, first 5 weeks 1 per day. Weeks 6–13: C157A (3 per week). After week 13: C159A (6 per month). Count from the day you were referred (GP43).	\$40.05
C122A	You're MRP: day after admission Once per admission; C142A instead if the day after transfer out of ICU (GP44, GP46).	\$71.80
C123A	You're MRP: second day after admission Once per admission; C143A instead after an ICU transfer.	\$71.80
C124A	You're MRP: day of discharge Stay 48+ hours, discharge summary within 48 hours, follow-up and discharge meds arranged (GP45).	\$71.80
C126A	You're MRP: complex discharge Stay 7+ days, 3+ diagnoses that lengthened it, 45+ min on the discharge (A13).	\$95.10
C158A	Concurrent care Family doctor stays MRP and asked you to keep directing care: 4 in the first week, then 2 per week (GP48).	\$40.05

- MRP? Every subsequent visit gets E083A (+30%), or E084A (+45%) on Saturday, Sunday or a holiday. Not with concurrent care (GP47).
- MRP day-after-admission and second-day visits pay \$71.80, not \$40.05 (GP44).
- After week 5, an acute intercurrent illness beyond the weekly or monthly limits is C121A (\$40.05) (GP43).
- In-patient re-assessment codes also exist: C153A \$95.95, C154A \$72.00, C151A \$83.40, C760A \$102.95 (A102).

Long-term care

W155A	Consultation Routine request in a nursing home, home for the aged or chronic care bed.	\$172.95
W150A	Comprehensive consultation, 75+ min Same conditions as A150A (A103).	\$342.25
W255A	Limited consultation Narrower question. Repeat consultation: W156A, same fee.	\$110.15
W760A	Complex endocrine neoplasm assessment Same conditions and limits as A760A (A103).	\$102.95
W152A	Chronic care hospital visit First 4 per patient per month; then W151A, up to 6 more. Palliative care visits: W982A (A103, GP50).	\$40.05
W153A	Nursing home visit First 2 per patient per month; then W158A, up to 3 more. Palliative care visits: W972A (A103, GP50).	\$40.05
W121A	Extra visit for an intercurrent illness Acute illness, not a special visit. Paid whatever the monthly limits (GP49).	\$40.05
A155A	Called in non-electively Bill the A code with the LTC special visit premiums (GP49, GP73).	\$172.95

- Special visit premiums never apply to elective LTC visits, even when the home is the patient's residence (GP66).
- You're the attending on admission: W252A \$69.35 (Type 1). Saw them before admission: Type 2 W254A \$20.60. Re-admitted after 3+ days elsewhere: Type 3 W257A \$30.70 (GP49, A103).
- Periodic health visit W259A \$65.05; the nursing home general re-assessment W154A (\$20.60) only 6 months after it (A103).
- Discharge after a 30+ day stay to another facility or home where a different provider takes over, with follow-up in the summary: W124A \$71.80. Not for respite stays (A20).

Video, phone or e-consult

A154A + K300A	Video follow-up Patient you've seen in person in the last 24 months, or consulted by video. Full fee (A66).	\$72.00
A154A + K301A	Phone follow-up Phone pays 85% of the in-person fee (A70).	\$72.00
A155A + K300A	Video consultation Consultations are video only, never phone (Appendix J).	\$172.95
K731A	Phone advice to another doctor or NP 10+ minutes, you give an opinion, both in Ontario. Not to arrange a visit or transfer, or mainly about results (A42–A43).	\$47.75
K739A	e-Consult reply Opinion sent through a secure server within 30 days. Max 6 per patient per 12 months, 400 a year (A48).	\$20.50

- E078A still applies by video or phone: 50% of the virtual fee (A74).
- K731A and K739A are not paid if you see the patient yourself that day or the next (A43, A49).
- The patient has to start the contact (or it's a needed follow-up of one). A check-in call you start isn't billable (A68).
- A151A, A153A, A154A, A158A and A760A can be done by phone; every consult and in-patient C code is video only (Appendix J).

Also bill, if it's true

E078A	Chronic disease premium (+50%) Established diagnosis on OHIP's list (250 diabetes, 585 CKD and others). Office or out-patient clinic only. Put the listed diagnostic code on the claim (GP25–26).	+50%
E082A	You admitted them as MRP (+30%) This consult is your admission assessment. Once per admission; not for transfers within the hospital (GP42).	+30%
E083A	You're the MRP (+30%) Weekday subsequent visit as most responsible physician (GP47).	+30%
E084A	You're the MRP, Saturday, Sunday or holiday (+45%) Only one of E083A or E084A per patient per day (GP47).	+45%
C101A	Patient seen in ICU or CCU Not with critical care, ventilatory or comprehensive care team fees (GP103).	\$9.10
G372A	Injection with the visit IM, SC or ID, each injection (J54).	\$4.55
G489A	Blood drawn in your office Venipuncture, adult or adolescent (J7).	\$3.54
G700A	The test or procedure was the only reason for the visit Once per visit for procedures marked +. Not in hospital, not with an assessment (J3).	\$8.80
K035A	Reported a driving concern to the MTO Mandatory medical report to the Ministry of Transportation, e.g. severe hypoglycaemia. More than 1 per 12 months: manual review with notes (A59).	\$36.25
K070A	Filled in the home care referral form You're most responsible for the patient's ongoing care. Paid on top of the visit; once per home care admission; not if they already get home care (A58–A59, GP9).	\$34.75

Did a procedure or test?

Z771A	Thyroid nodule fine needle aspiration biopsy Independent procedure (W1, SP4).	\$38.00
J149	Ultrasound guidance of the FNA (professional part) Bill J149C. The technical part (J149B \$47.30) is only payable in a hospital (G2, G11).	\$56.45
Z726A	Thyroid cyst aspiration	\$38.00
G318A	Long-acting implant inserted (non-biodegradable) Done personally; not for injected or biodegradable implants (J41).	\$42.00
G493A	ACTH stimulation test, per injection	\$6.25
G501A	TRH or LHRH test, per injection	\$6.25
G497A	Insulin hypoglycaemia pituitary test With or without TRH and LHRH.	\$49.80
G495A	Glucagon test, type B For hypertension, pheochromocytoma or insulinoma, incl. cold pressor.	\$42.30
G494A	Glucagon test, type A Carbohydrate response.	\$10.20
G338A	Clonidine suppression test Physician present; includes the blood draws.	\$24.90
G358A	Growth hormone exercise stimulation test Physician present; includes the blood draws.	\$24.90
G337A	Water deprivation (ADH response) test Includes the 8-hour deprivation.	\$16.95
G341A	Hypertonic saline infusion test	\$16.95
G498A	IV glucose tolerance test	\$10.20
G513A	Pentagastrin stimulation for calcitonin	\$42.30
G344A	Phentolamine test	\$42.30
G515A	Indirect calorimetry (resting energy expenditure)	\$46.30
G373A	Injection was the only reason for the visit First injection; more injections are G372A.	\$7.90
G379A	IV started	\$6.15

Can I bill these together?

Code	With	Together ?	Why
A155A,A150A,A255A,A156A	A153A, A154A, A151A, A158A, A760A	No	Only one consultation or assessment is paid for the same visit (GP10).
A760A	E078A	No	E078A is not payable with A760A (A98).
E078A	A153A, A154A, A151A, A158A	Yes	E078A adds 50% to a medical specific assessment, re-assessment, complex re-assessment or partial assessment in the office or out-patient clinic (GP25).
E078A	C153A, C154A, C151A, A155A, A150A, C155A, W155A	No	E078A only adds to office or out-patient assessments, not consultations, in-patient, ED or LTC services (GP25).
K045A	K046A	Yes	K046A is payable in addition to K045A (A101).
K045A,K046A	A153A, A154A, A151A, A158A, A760A	Yes	No same-day restriction is listed; claim once the 12 months of required elements are complete (A99–A101).
G500A,G514A,G520A	A155A, A153A, A154A, A151A, A158A, A760A	Sometimes	Payable in the same month, but a contact on the same day as a consult or assessment doesn't count as a contact (J42).
G500A	G514A, G520A	No	Only one of G500A, G514A and G520A per patient per physician per month (J42).
G514A	G520A	No	Both in one month are paid as G520A only (J43).
K013A,K033A	A155A, A150A, A153A, A154A, A151A, A158A, A760A	No	With counselling, no consult or assessment is paid the same day; only injections, blood draws, interviews and a few forms (GP58).
K013A	K033A	Yes	First 3 units per patient per 12 months are K013A, the rest K033A (GP58).
K013A,K033A	G372A, G489A, K002A, K003A, K035A, K038A, G590A, G846A	Yes	On the list of services payable with counselling (GP58).
K035A,K070A	A155A, A150A, A255A, A156A, A153A, A154A, A151A, A158A, A760A	Yes	Paid on top of the visit: the MTO report has no same-day limit (A59), and the home care referral form is paid in addition to the assessment (A58).
K013A,K033A	K070A, K738A	No	Not on the list of services payable the same day as counselling (GP58).
K002A	A153A, A154A, A151A, A158A	Sometimes	Only when the interview is separately booked, 20+ minutes, and not the history-taking for the visit (GP61).
K731A,K739A	A155A, A150A, A153A, A154A, A151A, A158A, A760A, C155A, C152A, K013A	No	Not paid when the consultant sees the patient (consult, assessment, visit or K time code) the same day or the next day (A43, A49).
Z771A	A155A, A150A, A153A	Sometimes	Both paid when you decided on the FNA at this visit. If it was planned at an earlier visit, only A158A is payable before it that day (SP4).
Z771A	A154A, A151A, A760A	Sometimes	If the FNA was decided at an earlier visit in the past 12 months, only a partial assessment (A158A) is payable before it the same day (SP4).
Z771A	J149	Yes	Ultrasound guidance of the aspiration is billed by the physician who guides it (G11).
G373A	A155A, A150A, A153A, A154A, A151A, A158A, A760A	No	G373A is for an injection that was the only reason for the visit; with a visit bill G372A per injection. Each extra injection after G373A is G372A (J54).
G700A	A155A, A150A, A255A, A156A, A153A, A154A, A151A, A158A, A760A	No	G700A is only for a visit where a + procedure was the sole reason, not with an assessment (J3).
G700A	G373A	No	Injections aren't marked (+): an injection alone is G373A, without G700A (J3, J54).
E083A	E084A	No	Only one of E083A or E084A per patient per day (GP47).

Code	With	Together ?	Why
E083A,E084A	C158A, C155A, C153A	No	E083A/E084A only add to subsequent visits by the MRP, not consults or concurrent care (GP47).
E082A	C152A, C122A, C123A, C124A, C126A, E083A	No	E082A only adds to the MRP's admission assessment and no other service or premium (GP42).
C122A,C123A	C124A, C126A	No	C122A and C123A aren't paid the same day as a discharge visit (GP44).
C124A	C126A	No	Only one of C124A or C126A per admission (A13).
C122A	C142A	No	Only one of C122A or C142A per admission (GP44, GP46).

From the Ontario Schedule of Benefits (effective July 1, 2026): Endocrinology & Metabolism pages A98–A103, Practice in General A42–A49 and A58–A60, the General Preamble, Diagnostic & Therapeutic Procedures (J41–J43, J53–J55), Endocrine Surgical Procedures (W1) and Diagnostic Ultrasound (G2, G11). OHIP adds age premiums on the remittance (GP64: +10% to +30% on specialist consultations and procedures for patients under 16), so they are not in these totals. Video and phone amounts assume OHIP's 85% phone rate; E078A on a virtual visit is 50% of the virtual fee. Percentage premiums are shown on the fee of the code picked. Check your remittance advice if a fee looks different.

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