

Otolaryngology OHIP Billing Cheat Sheet 2026

OHIP specialty 24 · Procedure-only visit · Urgent call to a ward patient · In-patient consult (non-urgent) · Updated October 2026

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

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

Office consultation

A245A	Consultation Written referral from a physician or NP in the chart; report back to them (GP16).	\$92.70
A935A	Long consultation, 50+ minutes Special surgical consultation: 50+ minutes face to face, not counting scopes, procedures or chart review. Chart start and stop times (GP19–GP20).	\$194.65
A246A	Repeat consultation Same problem again after another doctor treated it in between. Needs a new written referral (GP19).	\$53.65
A243A	No written referral Paid as a specific assessment: full history of the complaint and detailed exam (GP16, GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$44.75

- Scoped the nose, nasopharynx or larynx? Add Z296A (\$33.25) on top of the consult, as long as it was the only operative procedure that day (P1).
- Did a nasal biopsy, polypectomy, foreign body removal, cautery or packing through the flexible scope? Bill that code plus E839A (\$35.25) instead of Z296A (P1, P4).
- A935A pays \$194.65, more than double A245A, when you spend 50+ minutes with the patient. Time spent scoping doesn't count (GP19–GP20).
- One consult per patient per diagnosis every 2 years; a clearly unrelated diagnosis allows 1 per 12 months (GP17).
- Booking a procedure for a later visit? On that day only a partial assessment (A244A) is paid with a Z procedure (SP4).

Follow-up visit

A244A	Follow-up check Partial assessment: history of the complaint, the exam needed, advice (GP25).	\$30.45
A243A	Full work-up of a new or different problem Specific assessment: full history of the complaint and detailed exam (GP23). Limit: 1 per 12 months (2 if a clearly different diagnosis).	\$44.75

- Debrided an ear with real outer or middle ear pathology under the microscope? Z907A (\$27.40) pays double G420A. Not for wax, and not with loupes or a headlight (Y16).
- G420A is only insured for impacted wax causing hearing loss after drops failed, or wax that has to come out to see the drum (J97).
- A scope or procedure you planned at an earlier visit allows only A244A with it, not A243A (SP4).
- Specific assessments are capped at 1 per patient per 12 months (2 for a clearly different diagnosis); extras are paid as A244A (GP23).
- E078A (chronic disease premium) isn't payable to otolaryngology (24): 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-only visit

- Microscopic debridement: Z907A one ear \$27.40; the other ear at 85% (Y16). G420A can't be added (J97).
- Z915A (simple foreign body) for wax alone pays \$0 (Y14).
- Z912A or Z914A in an otherwise healthy child needs chronic effusion lasting 3+ months or recurrent acute otitis with effusion (Y16).
- Epley (G403A) and ear syringing (G420A) take G700A (\$8.80) when they were the only reason for the visit; not in hospital (J3, J97).
- ENT office procedures carry no E542A tray fee.

Called to the ED

A245A	Consultation A request on the hospital's common record counts as the written referral (GP16).	\$92.70
A935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
A243A	Specific assessment Your own patient, or no consult request.	\$44.75

- Use the A-codes here, not C-codes, with the ED special visit premiums. Chart the time you saw the patient (GP69).
- Nosebleed: cautery Z314A and anterior packing Z315A are per side; posterior packing Z316A covers both. Done through the flexible scope: add E839A (\$35.25) (P4).
- Non-elective procedure started 17:00–24:00 weekdays or any time on a weekend or holiday: E409A adds 50% to the procedure fee; nights 00–07: E410A adds 75% (SP2, GP104).

- Already at the hospital? Evenings, weekends and nights still earn the first person seen premium without travel (GP66).

Urgent call to a ward patient

A245A	Consultation Another physician's in-patient, non-elective request.	\$92.70
A935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
A243A	Specific assessment Another physician's patient seen urgently.	\$44.75

- Non-elective calls to a ward use A-codes with the in-patient premiums; routine ward consults are C245A with no premium (GP43, GP65).
- No premiums for patients seen on rounds or for elective admission assessments (GP65).
- The travel premium needs a trip from another location; not between buildings on the same hospital campus (GP66).

Hospital rounds

C242A	Routine visit, weeks 1 to 5 1 per day. Weeks 6 to 13: C247A (max 3 per week); after week 13: C249A (max 6 per month) (GP43).	\$31.00
C122A	You're the MRP: day after admission Once per admission; not the same day as C124A or C126A (GP44).	\$71.80
C123A	You're the MRP: second day after admission Once per admission (GP44).	\$71.80
C142A	You're the MRP: first visit after transfer out of the ICU Patient got critical care, ventilatory or comprehensive care just before transfer (not monitoring only), and you didn't give it. Instead of C122A: one of C122A/C142A per admission (GP46).	\$71.80
C143A	You're the MRP: second visit after transfer out of the ICU Instead of C123A: one of C123A/C143A per admission. Not the same day as C124A or C126A (GP46).	\$71.80
C124A	You're the MRP: discharge day Stay of 48 h+; discharge summary within 48 h with reason, procedures, diagnosis, discharge meds (GP45).	\$71.80
C126A	You're the MRP: discharge day, medically complex Stay of 7+ consecutive days, 3+ diagnoses that lengthened it, 45+ minutes of your own time; otherwise paid as a lesser fee. One of C124A/C126A per admission (A13, GP45).	\$95.10
C248A	Concurrent care Another doctor is the MRP and asked you to keep following (GP48).	\$31.00

- As MRP, the two days after admission and discharge day pay \$71.80 each instead of \$31.00 (GP44–GP45). Came from the ICU? C142A/C143A take the place of C122A/C123A (GP46).
- A long, complex stay (7+ days, 3+ contributing diagnoses, 45+ min on discharge day) pays C126A \$95.10 instead of C124A \$71.80 (A13).
- E083A adds 30% to your MRP subsequent visits, C121A, C122A–C126A, C142A, C143A and C982A, when the hospital doesn't pay you for in-patient care (GP47).
- After week 5, an acute intercurrent illness is C121A (\$40.05), outside the weekly visit limits (GP43). Palliative care visits as MRP: C982A \$40.05 (GP50).
- Visit limits count from admission, or from the referral date if the patient was referred to you in hospital (SP2). The surgeon can't bill the admission assessment unless it was the decision-to-operate visit (SP2).

In-patient consult (non-urgent)

C245A	Consultation Written request in the hospital chart (GP16).	\$92.70
C935A	Consultation, 50+ minutes Start and stop times charted (GP19–GP20).	\$194.65
C246A	Repeat consultation Same problem after another doctor treated it in between (GP19).	\$53.65
C243A	Specific assessment Full history of the complaint and detailed exam (GP23).	\$44.75
C244A	Specific re-assessment 2 per 12 months, except admissions (GP23).	\$31.00

- Called urgently instead of on rounds? Pick "Urgent call to a ward patient": the A-code plus premiums pays more.
- Bedside scope: add Z296A when it's the only operative procedure (P1).

Booked surgery (OR)

- Bilateral tubes: Z914A is a Z (independent) procedure, so each ear is claimed in full (SP4).
- Other procedures under the same anaesthetic: the main one at 100%, the others at 85%, unless the Schedule says otherwise (SP2).
- Tonsillectomy S063A already includes adenoidectomy; don't add S065A (S2).
- The surgical fee covers care until the first post-op visit; the decision-to-operate consult is billed separately (SP1, SP2).

Phone or video

A245A + K300A	Consultation by video Consults are video only, on an Ontario Health verified platform (A67–A68, Appendix J).	\$92.70
A244A + K300A	Follow-up by video Full fee.	\$30.45
A244A + K301A	Follow-up by phone Phone pays 85% of the in-person fee (A70).	\$30.45
A243A + K301A	Specific assessment by phone 85% of \$44.75 (A70).	\$44.75
A101A	Video, no relationship with the patient No in-person visit or video consult with you in the last 24 months (A66, A73).	\$20.00
A102A	Phone, no relationship with the patient • The patient has to ask for the visit, or it follows up one they asked for. Check-in calls and normal results aren't billable (A68). • If you find you need to look in the ears or scope, only the in-person visit is paid (A67). • A video consult counts as a relationship: follow-ups for 24 months can be by phone at 85% (A66). • Write in the chart whether it was phone or video.	\$15.00

Also bill, if it's true

G441A + G526A	Audiogram: pure tone plus speech You interpret it personally; testing by you, your trained employee or a hospital audiologist; keep qualification records or it pays \$0. Pure tone only: G440A + G525A, \$17.80 (J98–J99).	\$37.25
G442A + G529A	Tympanometry (impedance) Advanced hearing test: by you, or an audiologist employed by you or a public hospital (J98–J99).	\$5.66
G700A	The procedure was the only reason for the visit For G420A or G403A. Once per visit, not in hospital, not with a consult or assessment (J3).	\$8.80
E409A	Non-elective procedure started 17:00–24:00 weekdays, or daytime or evening on a weekend or holiday Adds 50% of the ticked procedure fees. Fractures and dislocations count; not for ED physicians on shift (GP103–GP104).	+50%
E410A	Non-elective procedure started at night, 00:00–07:00 Adds 75% of the ticked procedure fees (GP104).	+75%
E083A	You're the most responsible physician Adds 30% to MRP subsequent visits, C121A, C122A–C126A, C142A, C143A and C982A, if the hospital doesn't pay you for in-patient care (GP47).	+30%
K036A	Filled in the Northern Health Travel Grant form Specialist's part of the form; payable to the referring doctor and the specialist (A60).	\$10.25
K730A	Phoned another specialist for advice about this patient You're the referring doctor; 10+ minutes, start and stop times charted. Not to arrange a referral, a transfer or to discuss test results. Paid on top of today's visit; 1 per patient per day (A42–A44).	\$37.05
K738A	Sent an e-consult to another specialist You're the referring doctor; secure e-consult, answered within 30 days. Paid on top of today's visit; 1 a day, 6 per patient per 12 months (A48–A49).	\$16.45
K121A	In-patient case conference Per 10-minute unit (10, 16, 26, 36 min...). Pre-scheduled, with the MRP plus 2+ other physicians or regulated professionals; chart start/stop, participants and outcome. Paid with today's visit, as long as the visit was done outside the conference. Max 4 per patient per 12 months, 8 units a day (A31–A33).	\$37.05

Did a procedure?

Z296A	Flexible nasopharyngolaryngoscopy Only when it's the only operative procedure that day (P1).	\$33.25
G454A	Stroboscopy	\$16.80
Z907A	Microscopic ear debridement, one ear Real outer or middle ear pathology or a mastoid cavity; not wax (Y16).	\$27.40
Z907A	Microscopic ear debridement, other ear Contralateral side at 85% (Y16).	\$23.29
G420A	Ear syringing or curetting (wax), one or both ears Impacted wax with hearing loss after drops, or to see the drum (J97).	\$13.15
Z913A	Small perforation repair under local Other ear at 85% (Y17).	\$39.00
Z912A	Myringotomy, per ear	\$42.15
Z916A	Intratympanic injection, per ear Includes any myringotomy (Y16).	\$75.90
Z915A	Foreign body out of the ear, simple \$0 if it was only wax (Y14).	\$10.55
Z909A	Ear canal biopsy	\$25.85
Z904A	Ear polyp removal, office	\$25.85
G403A	Epley (particle repositioning) for BPPV	\$21.70
Z314A	Nosebleed cautery, per side	\$11.50
Z315A	Anterior nasal packing, per side	\$15.35
Z316A	Posterior nasal packing One or both sides.	\$35.50
E839A	Done through the flexible scope Add to cautery, packing, nasal biopsy, single polyp or foreign body (Z314A, Z315A, Z316A, Z309A, Z304A, Z311A) (P1, P4).	\$35.25
Z309A	Nasal biopsy, single	\$18.30
Z304A	Nasal polyp removal, single	\$21.00
Z311A	Foreign body out of the nose, local	\$10.55
F136A	Nasal fracture, closed reduction Includes septal manipulation (N34).	\$102.35
Z301A	Drain septal abscess or haematoma	\$55.60
Z510A	Drain peritonsillar or pharyngeal abscess	\$91.10
Z324A	Indirect laryngoscopy with biopsy or foreign body removal	\$44.70
Z111A	Frenotomy, no general anaesthetic	\$20.00
Z914A	Myringotomy with tube, per ear (OR) Both ears paid in full (SP4).	\$78.60
S063A	Tonsillectomy, with or without adenoidectomy	\$214.50
S065A	Adenoidectomy alone	\$101.25
M012A	Septoplasty	\$293.95
Z302A	Turbinate reduction, one or both sides	\$55.60
M083A	Endoscopic ethmoidectomy, per side Bilateral: add E844A \$200 (P6).	\$350.00

Can I bill these together?

Code	With	Together ?	Why
E078A	A243A, A244A	No	E078A is only paid to the specialties listed in GP25; Otolaryngology (24) isn't one of them (GP25).
A245A	A243A, A244A, A246A, A935A	No	Only one assessment is paid per visit (GP10).
A243A	A244A	No	Only one assessment is paid per visit (GP10).
A243A	Z296A, Z907A, Z913A, Z912A, Z916A, Z909A, Z904A, Z915A, Z309A, Z304A, Z311A, Z314A, Z315A, Z324A	Sometimes	Z codes are independent procedures. If you planned it at an earlier visit in the last 12 months, only a partial assessment (A244A) is paid before it that day (SP4).
A244A	Z296A, Z907A, Z913A, Z912A, Z916A, Z909A, Z904A, Z915A, Z309A, Z304A, Z311A, Z314A, Z315A, Z316A, Z324A, Z301A, Z510A, Z111A	Yes	A partial assessment is the visit allowed with a planned Z procedure (SP4).
A245A, A935A, C245A, C935A	Z296A, Z907A, Z913A, Z912A, Z916A, Z909A, Z904A, Z915A, Z309A, Z304A, Z311A, Z314A, Z315A, Z316A, Z324A, Z301A, Z510A, Z111A, Z914A	Yes	The consult where you decide on the procedure is the major pre-op visit, and it is paid with a Z procedure done the same day. No second assessment before it that day (SP4 §13, GP4).
K731A, K739A	A245A, A935A, A246A, A243A, A244A, C245A, C935A, C246A, C243A, C244A	No	The consultant side of a phone or e-consult isn't paid if you also see the patient (consult, assessment or visit) that day or the next (A43, A49).
Z296A	Z314A, Z315A, Z316A, Z309A, Z304A, Z311A, Z324A, Z301A, Z510A, F136A, Z907A, Z913A, Z912A, Z916A, Z909A, Z904A, Z915A, E839A	No	Z296A is paid only when it's the only operative procedure; through the scope, add E839A to cautery, packing, biopsy, polyp or foreign body instead (P1, P4).
Z296A	Z292A, Z293A, Z322A, Z323A	No	Z296A isn't paid with direct laryngoscopy the same day, and only when it's the only operative procedure (P1, P7).
G420A	Z906A, Z907A, Z908A, Z913A	No	G420A isn't paid with Z906A, Z907A, Z908A or Z913A (J97, Y16).
Z913A	Z908A, E323A	No	Z913A isn't paid with Z908A or E323A (Y17).
Z912A	Z916A	No	Intratympanic injection includes the myringotomy (Y16).
S063A	S065A	No	S063A already includes adenoidectomy (S2).
S063A	Z914A, Z912A, Z302A, M012A	Sometimes	Same anaesthetic: the main procedure at 100%, others at 85% (SP2); several Z procedures done together are each paid in full (SP4).
G700A	A245A, A935A, A246A, A243A, A244A, C245A, C243A	No	G700A is only for a visit where the procedure was the sole reason, and not in hospital (J3).
C122A, C123A	C124A, C126A	No	C122A and C123A aren't paid the same day as C124A or C126A (GP44).
C142A, C143A	C124A, C126A	No	C142A and C143A aren't paid the same day as C124A or C126A (GP46).
C122A	C142A	No	Only one of C122A or C142A per hospital admission (GP44, GP46).
C123A	C143A	No	Only one of C123A or C143A per hospital admission (GP44, GP46).

Code	With	Together ?	Why
C124A	C126A	No	Only one of C124A or C126A per hospital admission (A13).
M083A	M054A	No	M083A isn't paid with M054A: the ethmoidectomy may already include the maxillary antrostomy (P6).
E600A	E643A	No	The operating microscope add-on E600A isn't paid with laser microlaryngoscopy E643A (P7).
E083A	C248A	No	E083A is for the MRP; concurrent care means another doctor is the MRP (GP47–GP48).
E409A	E410A	No	One after-hours rate per procedure, by its start time (GP104).

Sources: Schedule of Benefits (July 1, 2026): General Preamble GP10–GP69 and GP104, Surgical Preamble SP1–SP4, Aural Y14–Y18, Respiratory P1–P11, Digestive S1–S4, Endocrine W1–W2, Lymphatic R2, Diagnostic and Therapeutic J3 and J97–J100, Otolaryngology A166–A167, Practice in General A31–A60 (case conferences, phone and e-consults, forms), Virtual Care A66–A75. Surgeon fees shown; assistant and anaesthesia units are billed by those physicians. Totals leave out age premiums (OHIP adds 10–30% for children on consults and procedures) and the 85% rate on second procedures under one anaesthetic (OHIP applies it on the remittance). Screening audiometry and tests requested by schools, employers or WSIB are uninsured (J98).

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