OHIP Payments for Cervical Cancer Screenings

Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

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Quick Reference Guide[1]

The purpose of this reference guide is to provide a general overview of the OHIP payment rules for the cervical cancer screening test. As of March 3, 2025, the Ontario Cervical Screening Program (OCSP)[2] introduced human papillomavirus (HPV) testing as the primary test for cervical screening, replacing cytology (Pap tests or Pap smears). The payment rules are found in the OHIP Schedule of Benefits[3] (the "*Schedule*"), Section J Diagnostic & Therapeutic Procedures, in the Gynaecology subsection.[4]

This guide contains the following sections:

(A) Cervical Cancer Screening: Recommended Schedule (G365)
(B) Follow-up Cervical Screening (G394)
(C) Cervical Cancer Screening in Addition to an Assessment
(D) Cervical Cancer Screening – Sole Procedure
(E) Cervical Cancer Screening as an Uninsured Service
(F) Intended Use of G365/G394

A: Cervical Cancer Screening – Collection of cervical cancer screening specimen(s) (G365)

Screening for cervical cancer via HPV is eligible for payment every 33 months, for patients 25-69 years of age for services provided between March 3, 2025, and March 31, 2028. For G365 services provided on or after April 1, 2028, it is limited to one per patient per 54-month period.

G365 is uninsured for patients less than 25 years of age. HPV is generally not recommended for patients over 70 years of age; therefore, testing for patients over the age of 70 is uninsured when the patient has had three or more normal tests in the previous 10 years.

If G365 is performed outside of hospital or ICHSC, physicians are eligible for an additional fee (E430).

To provide cervical cancer screenings, please use the Cancer Care Ontario's lab requisition[5] as Ministry of Health lab requisitions and hospital requisitions differ from this form.

[1] **Disclaimer**: Every effort has been made to ensure that the contents of this Guide are 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..

[2] Ontario cervical cancer screening Guidelines can be found at https://www.cancercare.on.ca/

[3] This Quick Reference Guide is based on the OHIP Schedule of Benefits (SOB), Physician Services, February 14, 2025 (effective March 3, 2025) (https://www.ontario.ca/files/2025-03/moh-schedule-benefit-2024-03-04.pdf).

[4] OHIP SOB, April 2025, page J47-J48

[5] Human Papillomavirus (HPV) and Cytology Tests Requisition (https://www.cancercareontario.ca/sites/ccocancercare/files/assets/OH-HPV-Screening-Requisition-EN.pdf)

Code	Descriptor	Fee
G365	Collection of cervical cancer screening specimen(s)	$12.00
E430	➢ when cervical cancer screening specimen(s) are collected outside of hospital or *ICHSC*, to G365	$11.95

B: Collection of additional cervical cancer screening specimen(s) (G394)

Additional cervical screening testing for any of the following purposes

- Follow-up test once after low grade cytology results, where the follow-up specimen(s) are collected between March 3, 2025, and September 30, 2026; or
- Once every 3 years for patients who are immunocompromised; or
- Follow-up test once, a minimum of 24 *months* after testing human papillomavirus (HPV)-positive for other high-risk subtype as defined by Ontario cervical cancer screening guidelines with normal/low grade cytology results; or
- Follow-up test once, a minimum of 24 *months* after discharge from colposcopy when increased screening is recommended by Ontario cervical cancer screening guidelines; or
- Repeat after an invalid HPV test or an unsatisfactory cytology test; or
- Post-hysterectomy vaginal vault testing for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy; or
- Where the physician is of the opinion that the patient is a member of a vulnerable group that may have difficulty accessing the services within the specified time period.

G394 is limited to once per patient per lifetime for vaginal vault testing post-hysterectomy for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy.

Physicians claiming G394 must document the clinical indication for the service in the patient's medical record. G394 is *not eligible for payment* if this documentation is not present.

If G394 is performed outside of hospital, physicians are eligible for an additional fee (E431).

The Ontario cervical cancer screening guidelines define the immunocompromised screening population as people who:

a) Have a cervix; and
b) Are, or have ever been, sexually active; and
c) Are asymptomatic; and
d) Are part of any of the following populations at higher risk of pre-cancer and cervical cancer:
    - People who are living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), regardless of viral load
    - People with congenital (primary) immunodeficiency
    - Transplant recipients (solid organ or allogeneic stem cell transplants)
    - People requiring treatment (either continuously or at frequent intervals) with medications that cause immune suppression for three years or more
    - People who are living with systemic lupus erythematosus (SLE), regardless of whether they are receiving immunosuppressant treatment
    - People who are living with renal failure and require dialysis.

Code	Descriptor	Fee
G394	Collection of additional cervical cancer screening specimen(s) for any of the following purposes	$12.00
E431	➢ when cervical cancer screening specimen(s) are collected outside of hospital or *ICHSC*, to G394	$11.55

C: Cervical Cancer Screening in Addition to an Assessment or Procedure

When a pelvic examination is a normal part of the following service, it is an included element and not separately billable:

- Consultation
- Repeat consultation
- General assessment
- General re-assessment
- Specific assessment
- Specific re-assessment
- Routine post-natal visit

Though physicians cannot claim G365 or G394 with the services listed above, if the service was performed outside of hospital, the additional fee (E430 or E431) is eligible for payment. E430 represents a cervical cancer screening whereas E431 represents an additional cervical cancer screening for the indications applicable to G394 (see section B of this guide).

For example, if a family physician performs a cervical cancer screening, outside the hospital or ICHSC, as part of a general assessment (A003), the appropriate codes to claim are A003 and E430.

If the cervical cancer screening is performed in conjunction with any assessments not listed above, the physician is eligible to be paid the appropriate assessment fee and G365 or G394, and the corresponding additional fee for services performed outside hospital.

Examples of assessments where G365 and G394 are separately billable include:

- Minor assessment
- Intermediate assessment
- Periodic health visit – adult age 18 to 64 inclusive
- Periodic health visit – adult 65 years of age and older

One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or ICHSC.

G365 and G394 are not eligible for payment when performed in conjunction with an insured colposcopy service, Z730, Z731 or Z787, by the same provider, for the same patient on the same date of service. One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or *ICHSC*.

a. If G365A or G394A are submitted with Z730A, Z731A, or Z787A, the ineligible service will be paid at $0 with explanatory code **'D7 – Not allowed in addition to other procedure'**.
b. If G365A or G394A is already paid previously, Z730A, Z731A, or Z787A will be reduced by the value of the G365A or G394A with explanatory code **'DC - Procedure Paid Previously Not Allowed in Addition to this Procedure'**.

D: Cervical Cancer Screening – Sole Procedure

In circumstances where the cervical screening is the sole reason for the patient visit, G700, the basic fee-per-visit premium is eligible for payment.

For example, if a patient presents for an additional cancer screening due to a low-grade cytology result and the requirements for any assessment have not been met, the appropriate codes to claim are G394, E431 and G700.

Refer to the OHIP Schedule for a complete overview of the payment rules associated with G700.[6]

E: Cervical Cancer Screening as an Uninsured Service

The OHIP Schedule states that cervical cancer screening in excess of the specified limits is not an insured services. In a situation where a patient requests a cervical cancer screening more frequently than the interval recommended by CCO and paid for by OHIP, the patient is responsible for the cost of the test.

Physicians should consider whether it is professionally appropriate for such a service to be provided; advocating for patients includes discussions with patients about why the test is not medically indicated and potential risks associated with unnecessary medical interventions.

If an uninsured cervical cancer screening is performed, then the physician should charge the patient directly for the G365 service (if it is not included in an associated, medically necessary patient visit) as well as E430 if the test is performed outside hospital. If the cervical cancer screening is the sole reason for the patient visit, then G700 may also be billed to the patient. However, in situations where there is discussion related to performing an uninsured screening, that is also an uninsured visit and an appropriate assessment (e.g., A001) may be billed to the patient in place of G700.

As described in the OMA's Physician's Guide to Uninsured Services (the "Guide")[7], physicians should use the appropriate codes in the OHIP Schedule and calculate the OMA suggested uninsured fee using the multiplier listed in the Guide.

For example, if a physician performs a cervical cancer screening on a patient outside hospital and in conjunction with a minor assessment that is also uninsured, the suggested fee to charge the patient is as follows:

Descriptor	OHIP Fee	OMA Suggested Fee[8]
A001 Minor assessment	$23.75	$68.40
G365 Collection of cervical cancer screening specimen(s)	$12.00	$34.60
E430 outside hospital	$11.95	$34.40
Total	**$47.70**	**$137.40**

[6] OHIP SOB, April 2025, page J3

[7] https://www.oma.org/member/section/practice-&-professional-support/billing-for-uninsured-services?type=topics, page 13

[8] 2025 OMA fees = 2.88 x current OHIP fee

The physician should inform the patient of the applicable charges prior to rendering the service, tick the box on the lab requisition that indicates the test is uninsured and make an appropriate record of the uninsured service. The lab requisition for uninsured cervical cancer screening may differ between laboratory facilities. Please clarify with your patient which laboratory they would use and use the appropriate requisition form. The patient will be required to deliver the cervical screening to the Specimen Collecting Station and pay the laboratory for the test when the sample is submitted, unless alternative arrangements are made through the physician's office. The laboratory does not have the capacity to bill the patient after the test has been performed. This process is identical to that for Prostate-Specific Antigen (PSA) or Vitamin D testing which are uninsured tests, or for specimens collected/ordered on uninsured patients.

The Guide provides additional guidance on charging a patient for uninsured services.

F: Intended Use of G365/G394 and E430/E431

The fee code descriptor G365 is only intended for the collection of cervical cancer screening specimens. In situations where physicians are performing an internal exam for other reasons (e.g. suspicion or presence of a sexually transmitted infection, pelvic pain, menstrual changes, a friable lesion, etc.), and are required to use a speculum, the cervical cancer screening code and/or additional payment for services performed outside hospital (E430 or E431), are not eligible for payment.

Document compiled by the OMA's Economics, Policy & Research department
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