OHIP Payments for Pap Smear

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 on the OHIP payment rules for the cervical cancer screening test Papanicolaou ("Pap") smear. The payment rules are found in the OHIP Schedule of Benefits[2] (the "*Schedule*"), Section J Diagnostic & Therapeutic Procedures, in the Gynaecology subsection.[3]

This guide contains the following sections:

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

A: Cervical Screening - Periodic Testing (G365)

Screening for cervical cancer via a Pap smear is eligible for payment every three years (33 months), for patients 21-70 years of age. 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.

While the current guidelines[4] recommend routine Pap screening once every 36 months, the OHIP Schedule period defines the limit as "one per patient, per 33 month period" in recognition that some patients may be seen just prior to the recommended time interval.

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

Code	Descriptor	Fee
G365	Papanicolaou smear - periodic	$8.65
E430	➢ when Pap smear is performed outside of hospital, to G365	$11.95

[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] This Quick Reference Guide is based on the OHIP Schedule of Benefits (SOB), Physician Services, March 19, 2020 (effective April 1, 2020) (http://www.health.gov.on.ca/en/pro/programs/ohip/sob/).

[3] OHIP SOB, April 2020, page J49

[4] https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/2156

B: Follow-up Cervical Screening (G394)

Pap smear testing performed outside of regular screening is payable for certain indications:

- In follow-up of an abnormal Pap smear;
- In follow-up of an inadequate Pap smear;
- On an annual basis for patients who are immunocompromised, e.g. HIV-positive or taking long-term immunosuppressants;
- For a patient with a history of oncogenic HPV-typing; 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.

Physicians who claim G394 must have documentation of an abnormal or inadequate Pap result for which a follow-up is required, documentation of the cause of the immunocompromised status or documentation of difficulties in accessing the service within the specified time period. G394 is not eligible for payment in the absence of the required documentation.

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

Code	Descriptor	Fee
G394	Papanicolaou smear - additional	$6.75
E431	➢ when Pap smear is performed outside of hospital, to G365	$11.55

C: Pap Smear in Addition to an Assessment

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 periodic Pap smear whereas E431 represents an additional Pap smear for the indications applicable to G394 (see section B of this guide).

For example, if a family physician performs a periodic Pap smear, outside hospital, as part of a general assessment (A003), the appropriate codes to claim are A003 and E430.

If the Pap smear 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

D: Pap Smear – Sole Procedure

In circumstances where the Pap smear 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 a repeat Pap smear due to a previous inadequate Pap smear 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.[5]

E: Pap Smear as an Uninsured Service

The OHIP Schedule states that periodic Pap smears in excess of the limit (once per patient, per 33 months) are not insured services. In a situation where a patient requests a Pap smear 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 Pap smear 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 Pap smear is the sole reason for the patient visit, then G700 may also be billed to the patient. However, in in situations where there is discussion related to performing an uninsured pap, that is also an uninsured visit and an appropriate assessment (e.g., A001) may be billed to the patient in place of G700.

[5] OHIP SOB, April 2020, page J3

As described in the OMA's Physician's Guide to Uninsured Services (the "Guide")[6], 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 Pap smear 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[7]
A001 Minor assessment	$23.75	$54.90
G365 Periodic Pap smear	$8.65	$20.00
E430 outside hospital	$11.95	$27.60
Total	**$44.35**	**$102.50**

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

The patient will be required to deliver the Pap smear 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.

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

The Pap smear tests are intended for cervical cancer screening only. 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 Pap smear 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
Please forward questions to economics@oma.org

[6] https://www.oma.org/member/section/practice-&-professional-support/billing-for-uninsured-services?type=topics, page 13
[7] 2020 OMA fees = 2.31 x current OHIP fee