Appraising the Pap Smear

Will Society, Insurers, Put Their Money Where the Value Is?

The Pap smear has been credited with saving thousands of lives that may otherwise have been lost to cervical cancer. Now, will pressures of poor reimbursement, bad press, and the threat of lawsuits drive some laboratories out of the Pap smear business?

After 25 years in the field, Carol Carriere, SCT(ASCP), still loves the challenge of cytotechnology. The work is demanding and it energizes her. Each cytology slide demands her skill, judgment, and intense training.

Still, she faces a silent pressure: each time she places a slide onto the microscope stage, she places her reputation and that of the field, under the microscope as well.

These are confusing times for cytotechnologists and cytopathologists who evaluate and interpret Pap smears. In the age of managed care and poor reimbursement, some anatomic pathology laboratories have been forced to price the Pap smear far below what it actually costs to perform the test.

Also, recent years have brought highly publicized medical malpractice suits against pathologists and cytotechnologists who allegedly missed abnormal cells in the Pap smears of patients with cancer. One case in Milwaukee even sought to bring homicide charges against a laboratory.

And what about automation? Will it improve testing? How will it affect the cost of the test?

The result is that laboratories faced with these uncertainties are wondering whether they want to continue offering the Pap smear. Some are dropping it.

This article begins a two-part series on the pressures facing cytology laboratories. This month, we'll focus on laboratories that are trying to hold onto Pap smear testing in a climate of poor reimbursement. Next month, we'll look at how litigation and automation are changing the field. But first, let's look at how these pressures began and how they are affecting the daily lives of those evaluating the Pap smear.

Evaluating Slides in a Post-CLIA Age

Working under stress isn't exactly new to the cytotechnologist. "When I first came into the field, some cytotechnologists were being paid by the slide—it was about 50 cents a slide," says Carriere, a cytology supervisor at the Los Angeles County—University of Southern California Medical Center. "There were cytotechnologists working two or three jobs to make a decent wage. I heard rumors of cytotechnologists reading 200 to 300 slides a day."

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) mandated that technologists only could screen 80 slides a day for diagnostic purposes plus 40 slides for quality control or quality assurance. That number later was changed to 100 slides a day that could be screened for any reason. Carriere considers the regulations a giant step forward, but a step that may have created some problems of its own.

Facing financial difficulties and inadequate reimbursement, some laboratories consider 100 slides the goal, not an upper limit of testing. "Some cytotechnologists can
screen 100 slides a day and have no problem—many cannot," says Carriere. "Different cytotechnologists have different skills. Some can assimilate cell changes and make a decision relatively quickly. Others may need to study the slide a little longer." The time it takes to screen a slide also may depend on the workload itself and the population from whom the specimens were taken.

"Cytotechnologists are receiving conflicting messages," says Carriere. "When techs feel the pressure to screen more slides, they’ll make more errors," says Carriere. "But they also fear that if they make errors, they’ll end up in court."

Compounding this, for some, is a lack of job security. What if a local laboratory no longer can afford to evaluate Pap smears and discontinues its service? For some, that prospect may not cause problems—cytotechnologists may be able to find work in another laboratory. For others, however, there may be no other laboratory in town. The cytotechnologist may need to move or train for another field.

A Misunderstood Test

When George N. Papanicolaou, MD, PhD, first introduced his finding of malignant cells in vaginal smears in the late 1920s, his audience was skeptical. Biopsy of tissue was the standard method of diagnosis. Later, he developed a method for collecting and evaluating the smears (subsequently known as the Papanicolaou smear, shortened to the Pap smear), which he presented to the medical community in 1941.

The method provided a way to screen a large number of women for precancerous conditions. The philosophy was that regular Pap smears from patients would provide clinicians with the yearly opportunity to detect cellular abnormalities that could signal the beginning of the cervical cancer, and the women could be treated early. Cytotechnology schools were instituted to train students in the evaluation of the smears. Today, approximately 65 schools are accredited by the Commission on Accreditation of Allied Health Programs in the United States.

Perhaps no other screening program relies so much on the human eye. Highly trained cytotechnologists must search for abnormalities among the 50,000 to sometimes more than 200,000 cells that each slide contains. Some have likened this process to the search for a needle in a haystack. If the cytotechnologist detects an abnormality, he or she refers the slide to the pathologist who either makes a diagnosis and recommends a course of action or requests another smear from the patient.

The Pap smear has been credited with markedly reducing the number of deaths from cervical cancer. According to the American Cancer Society, cervical cancer rates have dropped by a factor of 70% since the Pap smear was first introduced. The American Cancer Society predicts that in 1997, 4,800 women will die in the United States from cervical cancer.

1 (When Dr Papanicolaou published his 1941 study, he stated that cervical cancer killed 26,000 women each year—the decrease in deaths is even more substantial when you consider that the population has nearly doubled since that time.)

In its early stages, cervical cancer can be a quiet disease. It has virtually no symptoms at the onset, and without proper periodic screening it can remain undetected for years until it becomes incurable. The Pap smear allows early detection of the precancerous condition and curative treatment.

For all its merits, the Pap smear, like all laboratory tests, is not perfect. That fact, widely accepted by the medical community and the founding father of the test, has not been well communicated to the public, which often unrealistically expects laboratory tests to be nearly 100% accurate.

Anatomy of the Problem

The fact that few in the general public know what goes on behind laboratory doors may bruise many hard-working laboratory professionals’ egos. But, as most cytotechnologists and
cytopathologists can attest, it can become pretty hot under the limelight.

In 1987, the Wall Street Journal published a Pulitzer prize–winning series that showed the cytology laboratory at its worst. The author, Walt Bogdanich, painted a picture of a “Pap-screening industry kept afloat by overworked, undersupervised, poorly paid technicians.”

The articles pointed out some isolated but serious abuses that needed to be addressed and that were subsequently taken up in CLIA '88, which required additional quality assurance measures, proof of laboratory certification, slide retention, and limitations on the number of slides a cytotechnologist could screen in a day. Bogdanich described “Pap mills,” laboratories engaged in churning out the greatest number of slides, often at the expense of quality.

The series alerted many, who had assumed that the test was infallible, that indeed it was not and that the system had flaws that were not being addressed. Although the instances of abuses were isolated and far from the practices of most laboratories, pathologists and cytotechnologists feared that the public would view the negative portrayal as representative of the entire industry.

The Wall Street Journal coverage was unbalanced,” says R. Marshall Austin, MD, PhD, director of gynecologic cytology of the Department of Pathology at Roper Hospital, Calhoun, SC. “It made no attempt to look into the question of whether the existence of false-negatives necessarily indicates incompetent practice. The series implied that false-negatives were virtual evidence of substandard practice. There was no effort to look at the question of the extent to which false-negatives were an intrinsic problem in even the finest practices, and because of that, the public and regulatory officials went forth with a witch-hunt mentality. From that point on, false-negatives meant that something was done negligently.”

Due to the nature of the test, pathologists consider false-negatives unavoidable in Pap smear interpretation. The false-negative has been roughly defined as a smear that has been reported as negative by the laboratory, but which came from a patient later found to have a precancerous or cancerous condition. False-negatives can occur during collection, when the material collected from the patient is not sufficient to determine cellular abnormalities; during screening, when the cytotechnologist fails to detect abnormal cells; or during interpretation, when the pathologist does not recognize the abnormality as being significant.

How do you explain the inevitability of an occasional false-negative Pap smear to a public inundated with information, most of which is garnered during three-minute segments on the evening news? “The public’s perception of the Pap test has been unrealistic from the start,” says Thomas A. Bonfiglio, MD, professor and director of cytopathology in the Department of Pathology, University of Rochester Medical Center, Rochester, NY. “The public has come to expect that this test should be 100% accurate. It never was, and it never will be. Because of the nature of the test, even in the finest laboratory, the best that can be expected is somewhere around a 5% to 10% false-negative rate.” This rate, in general, is considered irreducible in current practice.

Pathologists emphasize that the Pap smear is a screening test rather than a diagnostic test, and that there has been no other screening test that even comes close to the Pap smear in its success.

Its Successes, Its Limitations

When the Pap smear is part of an annual exam, women have a better chance of having potentially malignant or malignant processes detected early. “The reason that Pap smears work well is that you have many opportunities to find the abnormality,” says Bonfiglio. “Cervical cancer is not a process that goes from normal to cancer in one year. In large part because of unrealistic expectations, patients feel it’s malpractice when they have a false-negative result.”

Bonfiglio says he was startled to learn that even some clinicians don’t understand how Pap smears are interpreted. Many mistakenly believe that the Pap test is automated. They don’t realize that the Pap test relies on the skill and careful study of a highly trained cytotechnologist and cytopathologist to detect abnormalities.
"Partially it's our own fault in that we've emphasized the value of the Pap smear, but haven't adequately explain the limitations of the test to the public and clinician," says Bonfiglio.

From these fundamental misunderstandings have sprung some of the most critical pressures facing the field:

- **Poor reimbursement.** If even some clinicians have sketchy knowledge about what happens during a Pap smear, where does that leave insurance companies? In the dark, would seem to be the answer if you were to look at the reimbursement rates for Pap smears. Despite expert recommendations, the Health Care Financing Administration and most private insurers consider the Pap smear a clinical laboratory test, and set reimbursement in accordance with highly automated tests. Medicaid rates, set by individual states, are similar to those for Medicare.

- **Litigation.** According to Richard Anderson, MD, chair of the Board of Governors of the Doctors' Company, which insures physicians for medical malpractice claims, the number of malpractice lawsuits filed against pathologists performing Pap smears has increased threefold since 1992. And, because the injury alleged is usually severe and involves a woman with cervical cancer, the claims are for large amounts of money, says Anderson. Threats of litigation and the escalating cost of malpractice insurance factor into the laboratory's base cost, too.

- **Automation.** No one is sure how automation will affect the field. Some computerized technologies that match programmed abnormal cells with cells on a slide are used for rescreening. Other technologies "wash" debris from the sample, allowing for a cleaner specimen for the cytotechnologist to evaluate. Still other instruments attach to the microscope stage and monitor the areas of the slide the cytotechnologist examined. Although these technologies show promise, many pathologists are asking, "At what cost?" They fear that an increase in the cost of the Pap smear will cause a dangerous rift between those who can afford the Pap smear and those who can't.

All of these factor into a complicated series of problems for the cytology laboratory. It's as if each new pressure adds more weight to an unsteady house of cards. If the walls cave in, will the Pap test exist as we know it?

### The Roots of Poor Reimbursement

An old marketing ploy used by laboratories to increase business may be indirectly to blame for poor reimbursement. For many years, laboratories had marketed the Pap smear as a "loss leader," knowingly pricing the test below cost, hoping to attract client physicians. After the physician had established his or her relationship with the laboratory, it was hoped that other profitable tests, such as serology and microbiology, would follow. Theoretically, profits from these other tests would make up for the losses sustained by the Pap test. This practice, known as "cost-shifting" can be likened to a discount store's "blue-light special" where the expense of one service sold at a loss is shifted to another service.

When the Health Care Financing Administration set Medicare fee schedules in the early 1980s, it placed the Pap smear in the category of clinical laboratory tests, at a rate commensurate with other, often automated tests. In the mid-1990s, as managed care changed the way services were charged, insurance companies looked to these Medicare fee schedules as a benchmark, and set their reimbursement rates accordingly. The rate has not changed much in that time.

Today, laboratories are closely scrutinizing their costs and are realizing that those rates do not even come close to covering the test's costs.

"In my opinion, the loss-leader concept was working fine as long as there was adequate reimbursement from other sources," says Kirit Patel, MD, medical director of Associated Pathology Laboratories in Lexington, Ky, and technical...
George Nicholas Papanicolaou, MD, PhD, describes malignant cells in vaginal smears at the Third Race Betterment Conference in Battle Creek, Mich. The finding is poorly received by Papanicolaou's contemporaries. Diagnostic biopsy remains the method of choice for detecting cervical cancer.

With Herbert F. Traut, MD, a pathologist specializing in gynecologic material, Papanicolaou published "The Diagnostic Value of Vaginal Smear in Carcinoma of the Uterus" in the American Journal of Obstetrics and Gynecology. The authors describe methods of collection, staining, and interpretation, and state, "If by any chance a simple, inexpensive method of diagnosis could be evolved which could be applied to large numbers of women in the cancer-bearing period of life, we would be in a position to discover the disease in its incipiency much more frequently than is now possible."

In other words, when all insurance companies set up their own reimbursement schedules—and the majority of them were paying reasonably—the loss leader more or less equaled out to what it cost us to perform the service. The times have changed. Everyone wants to pay the same rate—the government, the Medicare programs, and private insurers. Private insurers, which have long paid premium rates, are asking "If you are willing to perform a service for a Medicare or Medicaid patient, why should we pay more for our clients and bear the cost?"

Susan Spires, MD, staff pathologist and cytopathologist at Saint Joseph Hospital in Lexington, also is keenly aware of the toll these practices have taken on the field. "The loss-leader approach has relegated the Pap test to an orphan in the field of pathology," she says. "This approach has always bothered me in an anatomic pathology service, especially one that is interpretive and highly complex," she says. "Any time you do a test in high numbers at a financial loss to achieve volume and income status elsewhere, you have devalued the importance of that test."

She adds that laboratories are harming themselves when they undervalue the test. "The spiral goes forever downward because you cannot get good cost accounting and you can't garner reimbursement to support the test," she says. "The threat to the Pap smear this past year is probably as significant as any threat to any service in medicine. We have a situation where we have a high-intensity service in terms of labor and expertise, and it is under extreme liability pressure."

And where will that leave the patient? "I think we're going to see a huge supply-side problem that will cause the cost of the Pap smear to boomerang and become so expensive that our underserved population will become even more underserved," says Spires. "We want to keep the Pap smear inexpensive, and we want to keep it available. We're not going to be able to do it this way."

What if increasing numbers of pathologists, like Spires, discontinue laboratory services and send more and more tests to distant reference laboratories? That trend is already occurring as managed care and cost cutting is driving practitioners' decisions on where to send tests. "Usually, a clinician or managed care company in Seattle that decides to send their Pap smears to a laboratory in Phoenix is basing the decision on cost rather than quality," says South Carolina–based pathologist Austin. He considers this a "very negative" trend in medicine and says he fears that local laboratories closing their doors will only exacerbate the problem.

"Most of us feel it is optimal to have the smear and the biopsy reviewed together in the same
1954

In the *Atlas of the Exfoliative Cytology*, Papanicolaou describes a five-class system of terminology of abnormalities. Class I, absence of atypical or abnormal cells; class II, atypical cytology but no evidence of malignancy; class III, cytology suggestive of, but not conclusive for malignancy; class IV, cytology strongly suggestive of malignancy; class V: cytology conclusive for malignancy. He cites Class V as being the only conclusive group. “Accuracy of close to 100 percent can be maintained in this group by competent and conservative utilization of the cytologic method. Of course, a varying degree of error in interpretation is to be expected in each of the other four groups.” Many pathologists objected to the interlaboratory variability of this classification system.

1956

William Christopher, MD, heads a massive screening project in Jefferson County, Ky. Many low-income women were included in the study. By its 11th year, more than 100,000 smears were being examined annually, and there was a notable decrease in incidence of new cancers. In 16 years, the death rate dropped from 23.7 to 10.2 per 100,000 women in Jefferson County.

1966

Ralph Richart, MD, proposes a classification system based on cervical intraepithelial neoplasm (CIN I, II, or III).

Canaries in the Mine

In 1985, the Kentucky Department for Health Services cited the state, particularly the eastern part, as having one of the highest mortality rates attributed to cervical cancer in the United States. The high incidence of cervical cancer was directly attributed to low rates of Pap smear screening brought on by barriers to access to health care facilities: poverty, lack of education, isolation, and social behavior patterns characteristic of the eastern Kentucky population. Through federally supported programs, efforts have been made to educate women and increase testing rates. The number of deaths from cervical cancer has dropped dramatically.

In the wake of this turnaround, Kentucky-based pathologists fear a backslide if laboratories no longer can afford to perform the Pap smears. “Lab services in this part of the country are vitally important for easy access and reasonable prices,” says Kentucky-based pathologist Patel. “If routine screening is stopped, what will happen? The average disease span from beginning to end is 10 years. Can you imagine no routine Pap smears for the next 10 years? We’ll go right back to where we were in the 1930s.”

In early 1996, Louisville-based Blue Cross/Blue Shield Anthem announced that it was lowering reimbursement of the Pap smear to $5.40, 75% of what Medicare was paying. Laboratory professionals were outraged.

In the typical bidding process, an insurance company will issue a letter to laboratories soliciting bids. It will ask the laboratories for prices and background information about the laboratory, such as documentation of quality control and quality assurance programs, client satisfaction surveys, and documentation pertaining to certification. The insurer considers the lowest bids and determines the best laboratories to serve a geographic area. In this instance, though, the insurance company used the Medicare rate as a benchmark.

Spires recognized an impossible situation. After taking a close look at what it costs to perform the Pap smear in her laboratory, she came up with $13 for a normal Pap smear and $16 for an abnormal. “It was ludicrous for me even to bid,” she says. “On top of that, there were additional prohibitive requirements, including financial review of all our tax documents, which I thought was analogous to looking into my pockets,” says Spires.

Under pressure from providers, the HMO agreed to increase reimbursement to $10 per test. It wasn’t enough. At that rate, Spires’ laboratory would continue to lose at least $3 for each normal Pap smear it performed. The situation was more complicated. Half of the laboratory’s business...
were patients covered by Medicare, Anthem, and another provider that paid only $7 per Pap smear. The laboratory also contracted with local physician offices, but after the laboratory dropped its Anthem account, the physician offices decided to contract with laboratories that could handle all of their accounts.

Spires felt there was no choice. The laboratory could no longer offer the Pap smear.

What if more laboratories, like hers, discontinue offering the Pap smear, she wonders. “I’m concerned in the short run about what’s going to happen to access, particularly in Kentucky,” says Spires. “I’m selfishly concerned about Kentucky. The demise of the Pap smear here would be tragic. Unfortunately, individuals like myself can’t afford to provide Pap interpretation anymore. We can’t cost shift.

“We’re just the canaries in the mine,” she adds. “We’re the first to go.”

Large Labs Feel the Pressure
It’s not only the small laboratories that are feeling the brunt of poor reimbursement. An April 1996 article in the Dark Report, a business intelligence service for clinical laboratory executives, reported that large commercial laboratories are subjecting their laboratory services to rigorous cost analyses and finding that the Pap smear is a major money loser. They’ve calculated the cost of the test to run around $15, and with Medicare-driven reimbursement rates, some are losing millions of dollars on the high-volume test. Some laboratories, according to the report, may refuse to bid on cytology contracts when reimbursement doesn’t cover the full cost of the tests. Whether laboratories will be able to move prices upward to recover full costs, the author speculated, could vary regionally according to competition.

Quest Diagnostics, a national laboratory company with headquarters in Teterboro, NJ, is trying to curb its losses on the Pap smear. The laboratory hired a full-time financial expert, Laura Hamilton, CPA, as business leader for anatomic pathology. She says that the focus on profitability is a philosophical shift for the laboratory. The laboratory’s focus is shifting away from the volumes of tests brought in to how profitable those tests are. “Understanding cost in this area is the new focus,” she says. “With Medicare reimbursement rates falling in the $7.50 range, we are finding that the laboratories are losing 50% on each test.”

Hamilton’s job is to evaluate and enhance the profitability of all anatomic pathology, including the Pap smear. The laboratory is attempting to tackle poor reimbursement by educating payers. Recently, company representatives approached a large West Coast payer and presented information...
on the value, labor-intensiveness, and true cost of the Pap smear. They were able to persuade the payer to double its reimbursement. She plans to handle other accounts in the same manner. “What we’re trying to do is take our example from our experience with the West Coast payer and use it across the company. We want to identify key payers and look at their reimbursement rates. If they’re below costs, we need to get out there and talk to them.”

“As pricing pressures really push, you need to look at how you participate in this business,” Hamilton says. “How do you provide outstanding screening, but make sure your company is around to do it.” (For a look at how another laboratory is tackling poor reimbursement, see “Tilting at Windmills? Moves in Washington.”)

Just How Much Does the Test Cost Anyway?
The difficult part about determining a uniform price for the Pap smear, however, is the variable costs. In a recent study, John W. Bishop, MD, used a formula derived from a business economics text to determine the cost of a Pap smear.7 He calculated the rate at $9.75 for a conventionally examined smear and $12.07 for a primary manual screen using a thin-smear preparation technique. He deliberately excluded variable costs, such as administrative costs, compliance with government regulations, courier services to transport specimens, marketing or client relations, laboratory information systems, billing and collections, and, most important, the bad debts associated with the residual small amounts routinely applied to the deductibles and the co-pay.

Unless the laboratory performs only one type of test, those costs are difficult to allocate among tests, he says. But those costs can be significant and can vary widely among laboratories in the industry. Larger commercial laboratories may be more likely to enjoy economies of scale.

The Kentucky Proposal: Make the Pap Smear a Medical Consultation
In September 1996, the Kentucky Medical Association passed a resolution that would reclassify the Pap smear as a medical consultation, placing it outside the bidding for “largely high-volume, automated serologic, hematologic, chemistry, and microbiologic test menus.”8 Proponents of the resolution believe that the Pap smear, due to its highly interpretive nature, does not belong in the same category as clinical laboratory tests. The purpose of the resolution is to take the Pap smear out of the “for-bid” category. This will move it into a category where it will be priced on a cost basis. The resolution was

1991 The Bethesda System is published. It includes a statement of adequacy and descriptive diagnoses that encompass benign cellular changes, epithelial abnormalities, ie, squamous cell lesions consisting of atypical squamous cells of undetermined significance, low- and high-grade squamous intraepithelial lesions, and carcinoma; and glandular cell lesions consisting of atypical glandular cells of undetermined significance and carcinoma.

1993 After a woman with cervical cancer dies, Newport Hospital’s cytology laboratory in Rhode Island is held to legal and public fire after it is revealed that the laboratory had failed to detect any abnormality on four consecutive Pap smears taken from the woman.

1994 Prime Time Live runs a story, “Rush to Read,” in which undercover reporters show laboratories that continue to pay by the slide and provide incentives for cytotechnologists to meet quotas, despite CLIA regulations. One of the cytotechnologists depicted screened slides in her own home.

1995 Doctors’ Company, a medical malpractice insurer, reports the number of malpractice claims filed for Pap smear jumps to 48 that year. By comparison, the number of lawsuits filed with the company in 1987 was 5.

Tilting at Windmills? Moves in Washington

Felix Martinez, MD, and David Hoak, MD, are on a quest. The pair, from Pathology Associates, PS, in Spokane, Wash, are attempting to increase reimbursement for the Pap smear, one managed-care payer at a time. For this pursuit of a seemingly impossible dream, Martinez has been dubbed ‘Don Quixote’ by colleagues. At first, he thought they might be right, but with each success, he realizes it’s not such an impossible quest after all.

These are not windmills they are fighting. Nor are they exactly dragons. They are managed care companies poorly educated about what is involved in a Pap smear. Hoak and Martinez decided to provide that education, just to see what would happen. They’ve had tremendous success, increasing proposed reimbursement by payers in some cases by six times their original proposed reimbursement rate.

Know Thine Enemy

In the beginning, the educational approach was a last-ditch attempt to keep the laboratory’s cytology business open.

“If managed care groups were going to reimburse based on Medicare standards, we would have to shut our doors. We’d have to tell the clinician, ‘we’ve performed your Pap screening for 40 years and have done a quality job, but we can’t afford to do it anymore,’” says Martinez. “And those clinicians would want the insurance company to tell them why.”

Rather than accept defeat, Hoak decided to pay a visit to one of the insurance companies. Perhaps payers simply didn’t understand the Pap smear, he reasoned. Perhaps they thought a smear was a smear was a smear and that the Pap smear was no different from a peripheral blood smear. What did he have to lose by talking with them? He set up an appointment with the senior reimbursement specialist at a managed care company and began the dialogue that would repeat itself with other payers and later with some Congressional representatives as well.

They take a team approach, including a pathologist, a financial person (an accountant, the chief executive officer, or a business manager), a cytotechnologist, and a clinician. They try to gain an audience with the insurer’s highest-level employee possible—preferably a medical director or physician who works with the medical director.

The payer’s representatives are invited to tour the laboratory and are shown the differences between each department. They then sit with Hoak and Martinez at a multiheaded microscope and are shown the difference between a blood smear and a Pap smear. They see firsthand the difference between the relatively clean monolayer of the blood smear and the complexity of the Pap smear. They are shown how the cell counter results clue the technologist in on what to look for in a blood smear, but how there are no such clues in the Pap smear. They see how the cytotechnologist must examine from corner to corner, edge to edge, searching for abnormalities among 50,000 to 200,000 cells.

“One of the analogies we use is Where’s Waldo?” says Hoak, referring to the series of books in which the reader searches a variety of crowded scenes to locate the hero. “We tell them a cytotechnologist has to search for ‘Waldo’ 80 times a day.” They also emphasize that every mistake is a potential lawsuit. “That catches the ear of the representatives, particularly the medical directors. They can empathize.”

Telling “The Pap Story”

After the Pap smear demonstration, Martinez shares what has been called “The Pap Story,” including the “triumph and tragedy” of the Pap smear. Triumph because cervical cancer incidence in the United States has decreased dramatically since the advent of the Pap smear. Tragedy because some women still die of the disease—most because they don’t have routine screening; some because of a sampling error; and some due to the “great nightmare” —when the laboratory misses the abnormality. He tells them how quality assurance is part of the price of a good Pap smear. He explains the loss-leader strategies and how the laboratory, at low reimbursement rates, loses money on every Pap slide it evaluates.

“When we talk about actual cost, we share with them our costs as well as the costs from six other labs,” says Hoak. They show direct and indirect costs. He explains that they lose $5 on every Medicare Pap smear, but that they must continue to process those tests to meet all of the needs of the clinicians who send them tests. They follow up with a list of what other payers pay and ask them for more.

“One of our intentions is to influence Medicare,” says Martinez. “We probably won’t change reimbursement, but we would like to get the Health Care Financing Administration to publicly state that its rate is not meant to be a benchmark for others—that it understands that its reimbursement is below cost, and that it encourages that every Pap smear be done in a quality manner with adequate reimbursement.”

“It’s a crusade, but not a full-time job,” says Hoak. “We will do this once every 3 or 4 months. We’re close to covering the whole state. Our goal is to branch into the political arena and also to encourage labs in other states to become involved.”
considered by the American Medical Association’s (AMA) House of Delegates in December 1996, and was referred for further study by the AMA Council on Medical Service, a policy-making body that deals with economic and social issues.

William A. Fogarty, MD, a pathologist who owns a private anatomic pathology laboratory in Wyoming, chairs the AMA Council on Medical Service. So far, the resolution’s terminology has been changed. “Medical consultation” would imply that the pathologist looks at every slide. Although he or she is legally and professionally responsible for each slide, the pathologist cannot review each one. Fogarty has changed the term to “physician service.” The service, he says, would be analogous to a family practice physician working with a physician’s assistant who consults the physician on difficult cases or routine reviews. That relationship is similar to that between the pathologist and cytotechnologist, says Fogarty.

The only obstacle, as Fogarty sees it, is that there is a limited amount of money for physician services under Part B of Medicare, which covers physician services. If reimbursement for the Pap smear falls under the new category, it will be competing with other physician services for federal dollars. After the council formulates a report on the resolution, the matter will be brought to the AMA House of Delegates, which will discuss it, along with other matters at its annual meeting in December. Fogarty is unwilling to make any predictions about the action the AMA House of Delegates will take, but says that if passed, the resolution may bring reimbursement for the Pap smear “back into the realm of reality. Maybe we can then get some adequate payment.”

Fogarty himself is wondering whether to continue offering Pap smear services. He recently performed a cost analysis and was surprised to discover that the laboratory made just over $1 on each of the 5,000 Pap smears it evaluated last year. He did not factor into the calculation the cost of his time to review the smears. “If I figured in my own time,” he says, “I would just close the books and say I’m not doing Pap smears anymore. Either we protect the Pap smear and bring reimbursement into reality or we’ll see a decline in the number of people doing Pap smears, a decline in the availability of the Pap smear, and potentially, a decline in quality. That will only hurt the patient.” Like other pathologists, Fogarty wonders whether his laboratory should discontinue Pap smear evaluation. “I can’t continue to give the service away,” says Fogarty. “It may be good medicine, but if I can’t pay my bills, where am I?”

If more laboratory professionals ask that question and ultimately discontinue the test, what will become of the Pap smear’s place in the fight against cervical cancer? Will society and insurers see the light? Or will the Pap smear become a test for only the economically privileged?

Laura Pelehach is managing editor of Laboratory Medicine.

References
8. Resolution submitted by the Fayette County Medical Society to the Kentucky Medical Association House of Delegates, 1996.