MINISTRY OF HEALTH
SINGAPORE

MediShield Life Claim Rules for Gastrointestinal Endoscopy and Related Procedures

CLAIMS MANAGEMENT OFFICE

AUGUST 2022

Contents

Definitions

Terminology	**Definition**
Initial colonoscopy	Refers to the very first episode of colonoscopy for the patient
Subsequent colonoscopy	Refers to a short-term follow-up colonoscopy as a direct sequela of a diagnosis made/procedure performed
Surveillance (Secondary) colonoscopy	Refers to the follow-up colonoscopy for patients with a personal history of a condition
Initial gastroscopy	Refers to the very first episode of gastroscopy for the patient
Subsequent gastroscopy	Refers to a short-term follow-up gastroscopy as a direct sequela of a diagnosis made/procedure performed
Surveillance (Secondary) gastroscopy	Refers to follow-up gastroscopy for patients with a personal history of a condition
Single surgical/procedural episode	A single surgical/procedural episode refers to the entire suite of services provided during the time the patient arrives to the operating theatre complex until the patient leaves. If the patient requires anaesthesia, the continuous period under General Anaesthesia/Sedation is also defined under the same surgical episode.

General Comments

MediShield Life (MSHL) Claim Rules (CR) are not clinical practice guidelines but meant to guide the medical community on what constitutes an appropriate claim under MSHL. MSHL is a basic, universal national insurance scheme that is supported by government funding as well as by premiums paid by Singaporeans and residents. As such, there is a need to strike a balance between ensuring appropriate coverage and better protection against large bills for medically necessary treatments, whilst keeping premiums affordable for all.

2 As per the MediSave Manual published in 2020, **MSHL does not cover colonoscopies done for screening purposes for primary prevention. '**Primary prevention' refers to medical services for generally healthy individuals to prevent a disease from ever occurring, in the absence of medical indications, e.g., general medical or health screening packages, general physical check-ups, vaccinations, etc.

3 **However, screening for 'secondary prevention' can be claimed from MSHL** under the respective diagnostic gastro/colonoscopies under the subsection title of 'surveillance (secondary)' scopes. **Furthermore, diagnostic gastro/colonoscopies carried out to investigate clinical complaints** should be claimed under the existing TOSP codes e.g. SF702C (Table 2C), SF704C (Table 3A) and SF705C (Table 3B).

4 **MediSave (MSV) can be used for screening colonoscopies only where recommended**, subject to the prevailing TOSP withdrawal limit for colonoscopy procedures plus $300 per day for associated day surgery costs. Screening colonoscopies should be claimed under the TOSP code SF703C (Table 2C). Where polypectomy is carried out as part of the screening colonoscopy procedure, it can be claimed under SF706C (Table 3A) or SF707C (Table 3B) from MSV.

Colonoscopy Claim Rules

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF702C	2C	Colon, Colonoscopy, Fibreoptic with/without biopsy[1]	The procedure should be claimed in a **day surgery** setting except for the following conditions that may be claimed in an **inpatient** setting: a. Emergency admission for acute abdominal symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Suspected intestinal obstruction/subacute intestinal obstruction f. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: i. Extensive endoscopic mucosal resection ii. Endoscopic submucosal dissection iii. Endoscopic full thickness resection g. Endoscopic dilatation of GI stricture h. Frail/elderly patients for bowel preparation i. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** **Initial colonoscopy** 1. Uninvestigated symptoms attributable to lower GI system 2. Unexplained weight loss 3. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) 4. Search for primary cancer for known metastatic cancer where the primary cancer is not identified 5. Change in bowel habits for more than 2 weeks (excludes constipation) with no colonoscopy in the last 3 years for this indication a. In adults above the age of 18: refers to change in stool frequency and calibre; does not refer to change in stool colour 6. Constipation for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years for this indication 7. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 8. Haematochezia with colonoscopy in which patient presented with significant bleeding for the same indication during initial hospital admission 9. Mucus in stools with no colonoscopy in the last 3 years for this indication 10. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 11. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years 12. Suspected colonic pathology on radiologic imaging 13. Rectal Prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

[1] Includes extended ileoscopy

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<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr><td>SF702C</td><td>2C</td><td>Colon, Colonoscopy, Fibreoptic with/without biopsy</td><td></td><td>
14. Faecal Incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years
15. Suspected Foreign Body in Colon/Rectum
16. Anaemia of unknown source
17. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
18. Proctalgia for more than 2 weeks
19. Palpable mass on physical examination (abdominal examination/digital rectal examination)
20. Hereditary Nonpolyposis Colorectal Cancer Syndrome
21. Familial Adenomatous Polyposis and other polyposis syndromes

Subsequent colonoscopy for same or different clinical indication from previous colonoscopy
1. Megacolon decompression
2. Inflammatory Bowel Disease (IBD) – 1 scope 3-6 months after initiation of and response to medical treatment for endoscopic evidence of healing

Surveillance (Secondary) colonoscopy

<table>
<tr><th>SN</th><th>Clinical indication</th><th>Frequency</th></tr>
<tr><td>1</td><td>Patients with a history of colorectal cancer and an incomplete colonic assessment before treatment</td><td>1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment</td></tr>
<tr><td>2</td><td>Patients with a history of colorectal cancer and a complete colonic assessment before treatment</td><td>Follow-up scope may be claimed at 1 year, 3 years, 5 years after surgery and 3 yearly thereafter if no adenomatous polyps are detected at previous colonoscopy</td></tr>
</table>
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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF702C	2C	Colon, Colonoscopy, Fibreoptic with/without biopsy		3	Patients with an incomplete colonic assessment before colonic resection	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Patients with a complete colonic assessment before colonic resection	1 year after surgery and every 3 years after first colonoscopy if no adenomatous polyps are detected at previous colonoscopy
				5	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				6	Personal history of IBD	1 scope 8 years after initial diagnosis for all cases of IBD for surveillance of colonic dysplasia. Based on risk stratification following this scope, interval for subsequent surveillance colonoscopy to range from 1 to 5 years: a. High risk features: extensive colitis with severe active inflammation, stricture or dysplasia detected in the last 5 years, Primary Sclerosing Cholangitis (PSC), Colorectal Cancer (CRC) in first-degree relative <50 years of age b. Intermediate risk features: extensive colitis with mild/moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF702C	2C	Colon, Colonoscopy, Fibreoptic with/without biopsy		7	Personal history of colorectal polyps	1 to 3 years after polypectomy in the presence of high-risk features (>1cm, multiple, villous architecture); otherwise, 3 to 5 years after polypectomy for low-risk polyps
				8	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				9	Reassessment for planned treatment	Where needed a repeat scope may be claimed: a. For a second opinion of the lesion where a biopsy was not taken b. For biopsy to assess the lesion and the 'at risk' mucosa for surgical planning to determine the extent of procedure to be done

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF704C	3A	Colon, Colonoscopy, Fibreoptic with removal of polyp (single or multiple less than 1cm)[1]	The procedure should be claimed in a **day surgery** setting except for the following conditions that may be claimed in an **inpatient** setting: a. Emergency admission for acute abdominal symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Suspected intestinal obstruction/subacute intestinal obstruction f. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: i. Extensive endoscopic mucosal resection ii. Endoscopic submucosal dissection iii. Endoscopic full thickness resection g. Endoscopic dilatation of GI stricture h. Frail/elderly patients for bowel preparation i. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g. hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with single or multiple polyps less than 1cm removed** 1. Uninvestigated symptoms attributable to lower GI system 2. Unexplained weight loss 3. Positive FOBT/FIT 4. Search for primary cancer for known metastatic cancer where the primary cancer is not identified 5. Change in bowel habits for more than 2 weeks (excludes constipation) with no colonoscopy in the last 3 years for this indication a. In adults above the age of 18: refers to change in stool frequency and calibre; does not refer to change in stool colour 6. Constipation for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years for this indication 7. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 8. Haematochezia with colonoscopy in which patient presented with significant bleeding for the same indication during initial hospital admission 9. Mucus in stools with no colonoscopy in the last 3 years for this indication 10. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 11. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years 12. Suspected colonic pathology on radiologic imaging 13. Rectal Prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 14. Faecal Incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

[1] Includes extended ileoscopy

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<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr><td>SF704C</td><td>3A</td><td>Colon, Colonoscopy, Fibreoptic with removal of polyp (single or multiple less than 1cm)</td><td></td><td>15. Suspected Foreign Body in Colon/Rectum
16. Anaemia of unknown source
17. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
18. Proctalgia for more than 2 weeks
19. Palpable mass on physical examination (abdominal examination/digital rectal examination)
20. Hereditary Nonpolyposis Colorectal Cancer Syndrome
21. Familial Adenomatous Polyposis and other polyposis syndromes

Subsequent colonoscopy for same or different clinical indication from previous colonoscopy with single or multiple polyps less than 1cm removed
1. Megacolon decompression
2. Therapeutic treatment of polyps that were previously not removed
3. IBD: 1 scope 3-6 months after initiation of and response to medical treatment for endoscopic evidence of healing

Surveillance (Secondary) colonoscopy

<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Personal History of Colorectal Polyps</td><td>1 to 3 years after polypectomy in the presence of high-risk features (>1cm, multiple, villous architecture); otherwise, 3 to 5 years after polypectomy for low-risk polyps</td></tr>
<tr><td>2</td><td>Reassessment of suspected incomplete colonic polypectomy</td><td>1 scope within 6 months after polypectomy</td></tr>
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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF704C	3A	Colon, Colonoscopy, Fibreoptic with removal of polyp (single or multiple less than 1cm)		3	Patients with a history of colorectal cancer and an incomplete colonic assessment before treatment	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Patients with a history of colorectal cancer and a complete colonic assessment before treatment	Follow-up scope may be claimed at 1 year, 3 years, 5 years after surgery and 3 yearly thereafter if no adenomatous polyps are detected at previous colonoscopy
				5	Patients with an incomplete colonic assessment before colonic resection	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				6	Patients with a complete colonic assessment before colonic resection	1 year after surgery and 3 yearly after first colonoscopy if no adenomatous polyps are detected at previous colonoscopy
				7	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				8	Personal history of IBD	1 scope 8 years after initial diagnosis for all cases of IBD for surveillance of colonic dysplasia. Based on risk stratification following this scope, interval for subsequent surveillance colonoscopy to range from 1 to 5 years: a. High risk features: extensive colitis with severe active inflammation, stricture or dysplasia detected in the last 5 years, PSC, CRC in first-degree relative <50 years of age

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<tr><td>SF704C</td><td>3A</td><td>Colon, Colonoscopy, Fibreoptic with removal of polyp (single or multiple less than 1cm)</td><td></td><td colspan="3"><table>
<tr><td></td><td></td><td>b. Intermediate risk features: extensive colitis with mild/moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age</td></tr>
<tr><td>9</td><td>Reassessment for planned treatment</td><td>Where needed a repeat scope may be claimed:
a. For a second opinion of the lesion where a biopsy was not taken
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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF705C	3B	Colon, Colonoscopy, Fibreoptic with removal of polyp (multiple more than 1cm)[1]	The procedure should be claimed in a **day surgery** setting except for the following conditions that may be claimed in an **inpatient** setting: a. Emergency admission for acute abdominal symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Suspected intestinal obstruction/ subacute intestinal obstruction f. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: i. Extensive endoscopic mucosal resection ii. Endoscopic submucosal dissection iii. Endoscopic full thickness resection g. Endoscopic dilatation of GI stricture h. Frail/elderly patients for bowel preparation i. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with single or multiple polyps more than 1cm removed** 1. Uninvestigated symptoms attributable to lower GI system 2. Unexplained weight loss 3. Positive FOBT/FIT 4. Search for primary cancer for known metastatic cancer where the primary cancer is not identified 5. Change in bowel habits for more than 2 weeks (excludes constipation) with no colonoscopy in the last 3 years for this indication a. In adults above the age of 18: refers to change in stool frequency and calibre; does not refer to change in stool colour 6. Constipation for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years for this indication 7. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 8. Haematochezia with colonoscopy in which patient presented with significant bleeding for the same indication during initial hospital admission 9. Mucus in stools with no colonoscopy in the last 3 years for this indication 10. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 11. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years 12. Suspected colonic pathology on radiologic imaging 13. Rectal Prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 14. Faecal Incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

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17. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
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Subsequent colonoscopy for same or different clinical indication from previous colonoscopy with single or multiple polyps more than 1cm removed
1. Megacolon decompression
2. Therapeutic treatment of polyps that were previously not removed
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Surveillance (Secondary) colonoscopy

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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF705C	3B	Colon, Colonoscopy, Fibreoptic with removal of polyp (multiple more than 1cm)		3	Patients with a history of colorectal cancer and an incomplete colonic assessment before treatment	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Patients with a history of colorectal cancer and a complete colonic assessment before treatment	Follow-up scope may be claimed at 1 year, 3 years, 5 years after surgery and 3 yearly thereafter if no adenomatous polyps are detected at previous colonoscopy
				5	Patients with an incomplete colonic assessment before colonic resection	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				6	Patients with a complete colonic assessment before colonic resection	1 year after surgery and 3 yearly after first colonoscopy if no adenomatous polyps are detected at previous colonoscopy
				7	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				8	Personal history of IBD	1 scope 8 years after initial diagnosis for all cases of IBD for surveillance of colonic dysplasia. Based on risk stratification following this scope, interval for subsequent surveillance colonoscopy to range from 1 to 5 years: a. High risk features: extensive colitis with severe active inflammation, stricture or dysplasia detected in the last 5 years, PSC, CRC in first-degree relative <50 years of age

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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF708C	3C	Colon, Colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)[1]	The procedure should be claimed in a **day surgery** setting except for the following conditions that may be claimed in an **inpatient** setting: a. Emergency admission for acute abdominal symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Suspected intestinal obstruction/ subacute intestinal obstruction f. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: i. Extensive endoscopic mucosal resection ii. Endoscopic submucosal dissection iii. Endoscopic full thickness resection g. Endoscopic dilatation of GI stricture h. Frail/elderly patients for bowel preparation i. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)** 1. Uninvestigated symptoms attributable to lower GI system 2. Unexplained weight loss 3. Positive FOBT/FIT 4. Search for primary cancer for known metastatic cancer where the primary cancer is not identified 5. Change in bowel habits for more than 2 weeks (excludes constipation) with no colonoscopy in the last 3 years for this indication a. In adults above the age of 18: refers to change in stool frequency and calibre; does not refer to change in stool colour 6. Constipation for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years for this indication 7. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 8. Haematochezia with colonoscopy in which patient presented with significant bleeding for the same indication during initial hospital admission 9. Mucus in stools with no colonoscopy in the last 3 years for this indication 10. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 11. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years 12. Suspected colonic pathology on radiologic imaging 13. Rectal Prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 14. Faecal Incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

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16. Anaemia of unknown source
17. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
18. Proctalgia for more than 2 weeks
19. Palpable mass on physical examination (abdominal examination/digital rectal examination)
20. Hereditary Nonpolyposis Colorectal Cancer Syndrome
21. Familial Adenomatous Polyposis and other polyposis syndromes.

Subsequent colonoscopy for same or different clinical indication from previous colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)
1. Megacolon decompression
2. Therapeutic treatment of polyps that were previously not removed
3. IBD: 1 scope 3-6 months after initiation of and response to medical treatment for endoscopic evidence of healing

Surveillance (Secondary) colonoscopy

<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Personal History of Colorectal Polyps</td><td>1 to 3 years after polypectomy in the presence of high-risk features (>1cm, multiple, villous architecture); otherwise, 3 to 5 years after polypectomy for low-risk polyps</td></tr>
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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF708C	3C	Colon, Colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)		3	Patients with a history of colorectal cancer and an incomplete colonic assessment before treatment	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
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				7	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
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<tr><td rowspan="2">SF708C</td><td rowspan="2">3C</td><td rowspan="2">Colon, Colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)</td><td rowspan="2"></td><td></td><td></td><td>b. Intermediate risk features: extensive colitis with mild/moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age</td></tr>
<tr><td>9</td><td>Reassessment for planned treatment</td><td>Where needed a repeat scope may be claimed:
a. For a second opinion of the lesion where a biopsy was not taken
b. For biopsy to assess the lesion and the ‘at risk’ mucosa for surgical planning to determine the extent of procedure to be done</td></tr>
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TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF710C	1B	Colon, Sigmoid, Sigmoidoscopy (Flexible), Fibreoptic with/without biopsy	The procedure should be claimed in a **day surgery** setting except for the following conditions that may be claimed in an **inpatient** setting: a. Emergency admission for acute abdominal symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Suspected intestinal obstruction/subacute intestinal obstruction f. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: i. Extensive endoscopic mucosal resection ii. Endoscopic submucosal dissection iii. Endoscopic full thickness resection g. Endoscopic dilatation of GI stricture h. Frail/elderly patients for bowel preparation i. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** **Initial sigmoidoscopy** 1. Uninvestigated symptoms attributable to lower GI system 2. Unexplained weight loss 3. Positive FOBT/FIT 4. Search for primary cancer for known metastatic cancer where the primary cancer is not identified 5. Change in bowel habits for more than 2 weeks (excludes constipation) with no sigmoidoscopy in the last 3 years for this indication a. In adults above the age of 18: refers to change in stool frequency and calibre; does not refer to change in stool colour 6. Constipation for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no sigmoidoscopy in the last 3 years for this indication 7. Haematochezia (fresh red blood per rectum) without sigmoidoscopy in the last 3 years for this indication 8. Haematochezia with sigmoidoscopy in the last 3 years in which patient presented with significant bleeding for the same indication during initial hospital admission 9. Mucus in stools with no sigmoidoscopy in the last 3 years for this indication 10. Tenesmus (incomplete bowel movement sensation) without sigmoidoscopy in last 3 years for this indication 11. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no sigmoidoscopy 12. Suspected colonic pathology on radiologic imaging 13. Rectal Prolapse if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years 14. Faecal Incontinence if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years 15. Suspected Foreign Body in Colon/Rectum

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<tr><td>SF710C</td><td>1B</td><td>Colon, Sigmoid, Sigmoidoscopy (Flexible), Fibreoptic with/without biopsy</td><td></td><td>16. Anaemia of unknown source
17. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
18. Proctalgia for more than 2 weeks
19. Palpable mass on physical examination (abdominal examination/digital rectal examination)
20. Hereditary Nonpolyposis Colorectal Cancer Syndrome
21. Familial Adenomatous Polyposis and other polyposis syndromes

Subsequent sigmoidoscopy for same or different clinical indication from previous sigmoidoscopy
1. Megacolon decompression
2. IBD: 1 scope 3-6 months after initiation of and response to medical treatment for endoscopic evidence of healing

Surveillance (Secondary) sigmoidoscopy

<table>
<tr><th>SN</th><th>Clinical indication</th><th>Frequency</th></tr>
<tr><td>1</td><td>Patients with a history of colorectal cancer and an incomplete colonic assessment before treatment</td><td>1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment</td></tr>
<tr><td>2</td><td>Patients with a history of colorectal cancer and a complete colonic assessment before treatment</td><td>Follow-up scope may be claimed at 1 year, 3 years, 5 years after surgery and 3 yearly thereafter if no adenomatous polyps are detected at previous sigmoidoscopy</td></tr>
<tr><td>3</td><td>Patients with an incomplete colonic assessment before colonic resection</td><td>1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment</td></tr>
</table>
</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF710C	1B	Colon, Sigmoid, Sigmoidoscopy (Flexible), Fibreoptic with/without biopsy		4	Patients with a complete colonic assessment before colonic resection	1 year after surgery and 3 yearly after first sigmoidoscopy if no adenomatous polyps are detected at previous sigmoidoscopy
				5	Personal history of colorectal polyps	1 to 3 years after polypectomy in the presence of high-risk features (>1cm, multiple, villous architecture); otherwise, 3 to 5 years after polypectomy for low-risk polyps
				6	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				7	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				8	Personal history of IBD	1 scope 8 years after initial diagnosis for all cases of IBD for surveillance of colonic dysplasia. Based on risk stratification following this scope, interval for subsequent surveillance sigmoidoscopy to range from 1 to 5 years: a. High risk features: extensive colitis with severe active inflammation, stricture or dysplasia detected in the last 5 years, PSC, CRC in first-degree relative <50 years of age b. Intermediate risk features: extensive colitis with mild/moderate active

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th colspan="3">Clinical indications and frequency</th></tr>
<tr><td>SF710C</td><td>1B</td><td>Colon, Sigmoid, Sigmoidoscopy (Flexible), Fibreoptic with/without biopsy</td><td></td><td colspan="3"><table>
<tr><td></td><td></td><td>inflammation, pseudopolyps, CRC in first-degree relative >50 years of age</td></tr>
<tr><td>9</td><td>Reassessment for planned treatment</td><td>Where needed a repeat scope may be claimed:
a. For a second opinion of the lesion where a biopsy was not taken
b. For biopsy to assess the lesion and the ‘at risk’ mucosa for surgical planning to determine the extent of procedure to be done</td></tr>
</table></td></tr>
</table>

Oesophagogastroduodenoscopy (OGD) Claim Rules

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr><td>SF701I</td><td>1B</td><td>Intestine/ Stomach, Upper GI endoscopy with/ without biopsy[1]</td><td>The procedure should be claimed in a day surgery setting except for the following conditions that may be claimed in an inpatient setting:
a. Emergency admission for gastroscopy for acute symptoms
b. Symptomatic anaemia
c. Acute GI bleeding
d. Management of acute abdominal pain,
e. Suspected intestinal obstruction /subacute intestinal obstruction
f. Treatment of oesophageal varices
g. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as
i. extensive endoscopic mucosal resection
ii. endoscopic submucosal dissection
iii. endoscopic full thickness resection
h. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g. hepatic, cardiac, renal failure, frailty</td><td>This procedure may be claimed according to the rules below:

Initial gastroscopy
1. Uninvestigated symptoms attributable to upper GI system
2. Upper GI bleed (active or recent)
3. Chronic blood loss (FOBT/ FIT positive)
4. Iron deficiency anaemia (a subsequent scope can be claimed within 1 year should there be a persistent iron deficiency anaemia)
5. Abnormal imaging - thickened folds/ mass on radiology
6. Assessment before and after bariatric surgery
7. Assessment of percutaneous endoscopic gastrostomy (PEG)/ percutaneous endoscopic jejunostomy (PEJ) tube where needed (e.g., blocked/ dislodged tube, requirement for change to a low-profile PEG tube
8. Abnormal tumour markers (includes CA19-9, CEA)
9. Abnormal microRNA blood test result (e.g. GastroClear test)
10. Biopsy to obtain tissue from H. Pylori culture in patients that have failed eradication therapy at least twice
11. Variceal screening in patients with liver cirrhosis or fibrosis
12. Eosinophilic oesophagitis or gastritis

Subsequent gastroscopy
<table><tr><th>SN</th><th>Conditions</th><th>Frequency of claims for gastroscopy</th></tr><tr><td>1</td><td>Persistent symptoms (or H. Pylori infection) despite relevant diagnosis and treatment</td><td>Within 1 year for the same indication by another specialist for a second opinion</td></tr></table></td></tr>
</table>

[1] includes narrow band imaging and/or non-routine mapping biopsy of the stomach to detect intestinal metaplasia and/or digital chromatography examination

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th colspan="3">Clinical indications and frequency</th></tr>
<tr><td>SF701I</td><td>1B</td><td>Intestine/ Stomach, Upper GI endoscopy with/ without biopsy</td><td></td><td colspan="3">
<table>
<tr><td>2</td><td>Document previous gastric ulcer healing</td><td>Within 8 weeks. Should the ulcer not be healed, a further scope could be performed following another 4-8 weeks of medication.

Patients that need to restart antiplatelets/anticoagulants can also receive a further scope within 8 weeks after medication to check ulcer healing.</td></tr>
<tr><td>3</td><td>After bariatric surgery</td><td>1 year and then once every 2-3 years</td></tr>
<tr><td>4</td><td>After sleeve gastrectomy with reflux symptoms</td><td>As needed due to symptoms</td></tr>
<tr><td>5</td><td>Assessment after treatment of oesophageal varices</td><td>As needed (2-4 weekly) until complete eradication of oesophageal varices. Following this, one scope may be performed after 3 – 6 months</td></tr>
</table>
Surveillance (Secondary) Gastroscopy
<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Intestinal metaplasia</td><td>1-3 years</td></tr>
<tr><td>2</td><td>Dysplasia</td><td>6-12 months</td></tr>
<tr><td>3</td><td>Varices</td><td>Following the subsequent gastroscopy(es), one scope may be claimed every 6-12 months</td></tr>
<tr><td>4</td><td>Barrett's oesophagus</td><td>a. Patients with Barrett’s oesophagus shorter than 3 cm should receive endoscopic surveillance (1 scope) every 3–5 years. Patients with segments of 3 cm or longer should receive surveillance (1 scope) every 2–3 years.</td></tr>
</table>
</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF701I	1B	Intestine/ Stomach, Upper GI endoscopy with/ without biopsy				b. Where there is indefinite dysplasia or low-grade dysplasia for which no intervention is done, then a scope may be repeated in 6 months
				5	Achalasia	a. 1 scope every 2 or 3 years b. If a Per-Oral Endoscopic Myotomy (POEM) procedure was performed, 1 scope may be claimed 1 year after the procedure or in patients presenting with reflux symptoms
				6	History of caustic ingestion	1 scope every 2 or 3 years
				7	Hereditary Nonpolyposis Colorectal Cancer Syndrome	1 scope every 2-3 years from 30-35 years old onwards
				8	Polyposis Syndrome	Polyps larger than 1 cm performed yearly/polyps <1 cm performed every 2 to 3 years
				9	History of sporadic adenomata	1 scope may be claimed 1 year after resection of adenomatous or dysplastic polyps in stomach
				10	Previous gastrectomy (non-bariatric)	a. 1 scope every year up to 20 years from the time of gastrectomy b. In the case of total gastrectomy, surveillance scopes in 1, 3 and 5 years may be claimed
				11	Pernicious anaemia	1 scope every 2 or 3 years
				12	Atrophic gastritis	1 scope every 2 or 3 years
				13	Previous history of liver cirrhosis	a. Patients with advanced liver cirrhosis and found to have no varices on initial screening endoscopy but has a platelet count of less than 150,000/µL y: may claim 1 scope every 2 years,

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th colspan="3">Clinical indications and frequency</th></tr>
<tr><td rowspan="4">SF701I</td><td rowspan="4">1B</td><td rowspan="4">Intestine/ Stomach, Upper GI endoscopy with/ without biopsy</td><td rowspan="4"></td><td></td><td></td><td>with the first scope claimed within 6 months from time of diagnosis
b. Patients with advanced liver cirrhosis, found to have small varices on initial screening endoscopy, and a platelet count of less than 150,000/µL may claim within 6 months from time of diagnosis - 1 scope annually</td></tr>
<tr><td>14</td><td>Previous treatment for oesophageal cancer</td><td>a. Where chemo-radiotherapy had been performed with a complete response without esophagectomy, 1 scope may be claimed
i. every 3 months for the first 2 years,
ii. every 6 months thereafter in the 3rd year, and
iii. annually in the 4th and 5th year
b. Where chemotherapy and surgery (esophagectomy) had been performed, a scope may be claimed at 1, 3, 5 years post therapy</td></tr>
<tr><td>15</td><td>Reassessment for planned treatment</td><td>Where needed a repeat scope may be claimed:
a. For a second opinion of the lesion where a biopsy was not taken
b. For biopsy to assess the lesion and the ‘at risk’ mucosa for surgical planning to determine the extent of procedure to be done</td></tr>
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<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr>
<td>SF700I</td>
<td>2C</td>
<td>Intestine/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions/ injection of varices/ removal of single polyp</td>
<td>The procedure may be claimed in a day surgery or claimed as an inpatient episode in the presence of the following clinical criteria:

a. Emergency admission for gastroscopy for acute symptoms
b. Patient with medical comorbidities that require pre/post procedural management and monitoring
c. Symptomatic anaemia
d. Acute GI bleeding
e. Management of acute abdominal pain,
f. Suspected intestinal obstruction/ subacute intestinal obstruction
g. Treatment of oesophageal varices
h. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as
i. extensive endoscopic mucosal resection
ii. endoscopic submucosal dissection
iii. endoscopic full thickness resection
i. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty</td>
<td>This procedure may be claimed according to the rules below:

Initial gastroscopy
1. Uninvestigated symptoms attributable to upper GI system
2. Upper GI bleed (active or recent)
3. Chronic blood loss (FOBT/FIT positive)
4. Iron deficiency anaemia
5. Abnormal imaging - thickened folds/mass on radiology
6. History of known varices (scheduled eradication)
7. Lesions identified during diagnostic gastroscopy such as polyps
8. Foreign body
9. Change of percutaneous endoscopic gastrostomy (PEG)/ percutaneous endoscopic jejunostomy (PEJ) tube where needed (e.g., blocked/dislodged tube, requirement for change to a low-profile PEG tube
10. Abnormal tumour markers (includes CA19-9, CEA)
11. Abnormal microRNA blood test result (e.g., GastroClear test)
12. Biopsy to obtain tissue from H. Pylori culture in patients that have failed eradication therapy at least twice
13. Variceal screening in patients with liver cirrhosis or fibrosis
14. Eosinophilic oesophagitis or gastritis

Subsequent gastroscopy

<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency of claims for gastroscopy</th></tr>
<tr><td>1</td><td>Persistent symptoms (or H. Pylori infection) despite relevant diagnosis and treatment</td><td>Within 1 year for the same indication by another specialist for a second opinion</td></tr>
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<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr><td>SF700I</td><td>2C</td><td>Intestine/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions/ injection of varices/ removal of single polyp</td><td></td><td>
<table>
<tr><td>2</td><td>Document previous gastric ulcer healing</td><td>Within 8 weeks should the ulcer not be healed; a further scope could be performed following another 4-8 weeks of medication.
Patients that need to restart antiplatelets/anticoagulants can also receive a further scope within 8 weeks after medication to check ulcer healing.</td></tr>
<tr><td>3</td><td>After bariatric surgery</td><td>1 year and then once every 2-3 years</td></tr>
<tr><td>4</td><td>After sleeve gastrectomy with reflux symptoms</td><td>As needed due to symptoms</td></tr>
<tr><td>5</td><td>Assessment after treatment of oesophageal varices</td><td>As needed (2-4 weekly) until complete eradication of oesophageal varices. Following this, one scope may be performed after 3 – 6 months</td></tr>
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<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Intestinal metaplasia</td><td>1-3 years</td></tr>
<tr><td>2</td><td>Dysplasia</td><td>6-12 months</td></tr>
<tr><td>3</td><td>Varices</td><td>Following the subsequent gastroscopy(es), one scope may be claimed every 6-12 months</td></tr>
<tr><td>4</td><td>Barrett's oesophagus</td><td>a. Patients with Barrett’s oesophagus shorter than 3 cm should receive endoscopic surveillance (1 scope) every 3–5 years. Patients with segments of 3 cm or longer should receive surveillance (1 scope) every 2–3 years</td></tr>
</table>
</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency		
SF700I	2C	Intestine/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions/ injection of varices/ removal of single polyp				b. Where there is indefinite dysplasia or low-grade dysplasia for which no intervention is done, a scope may be repeated in 6 months
				5	Achalasia	a. 1 scope every 2 or 3 years b. If a Per-Oral Endoscopic Myotomy (POEM) procedure was performed, 1 scope may be claimed 1 year after the procedure or in patients presenting with reflux symptoms c. Recurrence of symptoms
				6	History of caustic ingestion	1 scope every 2 or 3 years
				7	Hereditary Nonpolyposis Colorectal Cancer Syndrome	1 scope every 2-3 years from 30-35 years old onwards
				8	Polyposis Syndrome	Polyps larger than 1 cm performed yearly/polyps <1 cm performed every 2 to 3 years
				9	History of sporadic adenomata	1 scope may be claimed 1 year after resection of adenomatous or dysplastic polyps in stomach
				10	Previous gastrectomy (non-bariatric)	a. 1 scope every year up to 20 years from the time of gastrectomy b. In the case of total gastrectomy, surveillance scopes in 1, 3 and 5 years may be claimed
				11	Pernicious anaemia	1 scope every 2 or 3 years
				12	Atrophic gastritis	1 scope every 2 or 3 years
				13	Previous history of liver cirrhosis	a. Patients with advanced liver cirrhosis and found to have no varices on initial screening endoscopy but has a platelet count of less

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th colspan="3">Clinical indications and frequency</th></tr>
<tr><td rowspan="4">SF700I</td><td rowspan="4">2C</td><td rowspan="4">Intestine/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions/ injection of varices/ removal of single polyp</td><td rowspan="4"></td><td></td><td></td><td>than 150,000/µL y: may claim 1 scope every 2 years, with the first scope claimed within 6 months from time of diagnosis
b. Patients with advanced liver cirrhosis, found to have small varices on initial screening endoscopy, and a platelet count of less than 150,000/µL may claim within 6 months from time of diagnosis - 1 scope annually</td></tr>
<tr><td>14</td><td>Previous treatment for oesophageal cancer</td><td>a. Where chemo-radiotherapy had been performed with a complete response without esophagectomy, 1 scope may be claimed
i. every 3 months for the first 2 years,
ii. every 6 months thereafter in the 3rd year, and
iii. annually in the 4th and 5th year
b. Where chemotherapy and surgery (esophagectomy) had been performed, a scope may be claimed at 1, 3, 5 years post therapy</td></tr>
<tr><td>15</td><td>Reassessment for planned treatment</td><td>Where needed a repeat scope may be claimed:
a. For a second opinion of the lesion where a biopsy was not taken
b. For biopsy to assess the lesion and the ‘at risk’ mucosa for surgical planning to determine the extent of procedure to be done</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF700E	3A	Oesophagus/ Stomach, Gastroscopy and Dilatation	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. Patients that are dehydrated and/or malnourished state requiring inpatient care c. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** 1. Gastroscopy and Dilatation may be performed for benign stricture/stenoses

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Setting</th><th>Clinical indications and frequency</th></tr>
<tr>
<td>SF700C</td>
<td>3A</td>
<td>Capsule Endoscopy</td>
<td>The procedure should be claimed in a day surgery setting except for the following conditions that may be claimed in an inpatient setting:

a. Emergency admission for acute symptoms
b. Obscure GI bleeding
c. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty</td>
<td>This procedure may be claimed according to the rules below:
<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency of claims for capsule endoscopy</th></tr>
<tr><td>1</td><td>Repeat discrete episodes of obscure GI bleeding</td><td>-</td></tr>
<tr><td>2</td><td>Suspected small bowel pathology as cause of symptoms
a. Anaemia
b. Bleeding
c. Pain</td><td>-</td></tr>
<tr><td>3</td><td>Investigations of small bowel lesions found on imaging</td><td>-</td></tr>
<tr><td>4</td><td>Investigation of:
a. Anaemia
b. Abdominal pain</td><td>Once a year</td></tr>
<tr><td>5</td><td>Evaluation of ulcer healing in Crohn’s Disease</td><td>Once every 6 months</td></tr>
</table>
The procedure may be claimed together with another upper gastrointestinal endoscopic procedure in cases such as the following:
a. Investigation of occult anaemia
b. Patients with swallowing difficulties
c. Other indications for a pan-endoscopic evaluation</td>
</tr>
</table>

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF704E	3A	Oesophagus/ Stomach/ Colon, Gastrointestinal Endoscopy, Ablative Treatment	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** 1. Barrett's Oesophagus with dysplasia 2. Vascular lesions 3. Tumours

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF705E	3C	Oesophagus/ Intestine/ Stomach, Upper GI endoscopy with Endoscopic Submucosal Dissection	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. Symptomatic anaemia c. Acute GI bleeding d. Management of acute abdominal pain e. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as i. extensive endoscopic mucosal resection ii. endoscopic submucosal dissection iii. endoscopic full thickness resection f. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed up to twice a year. SF701I could be claimed within a year following SF705E as a follow-up procedure.** **Initial gastroscopy** 1. Early Gastric Cancer 2. Submucosal lesions of stomach 3. Dysplasia **Subsequent gastroscopy** 1. Early Gastric Cancer 2. Submucosal lesions of stomach 3. Dysplasia ** Please note that SF701I performed prior to ESD (SF705E) at a different surgical / procedural episode is claimable.

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF807E	3A	Oesophagus/ Intestine/ Stomach, Upper Gl endoscopy with insertion of Prosthesis	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. Patients that are dehydrated and/or malnourished state requiring inpatient care. c. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** 1. Anastomotic leakage 2. Fistula 3. Malignant tumour for palliative stenting a. Upper gastrointestinal tract tumour 4. Insertion of intra-gastric device for medical indications

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF808E	3A	Oesophagus/ Gastroscopy with Therapy- e.g., APC- Fulgarisation of Tumour	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** 1. Upper Gastrointestinal tumours 2. Angiodysplasia

TOSP Code	Table Code	TOSP Description	Setting	Clinical indications and frequency
SF813E	3A	Oesophagus/ Intestine/ Stomach, Upper GI endoscopy with complicated polypectomy (e.g., large polyp requiring multiple piecemeal resections, multiple polyps >2, or polyps with complications such as bleeding) or endoscopic mucosal resection	The procedure may be claimed in a **day surgery** or claimed as an **inpatient episode** in the presence of the following clinical criteria: a. Emergency admission for gastroscopy for acute symptoms b. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty	**This procedure may be claimed according to the rules below:** 1. Benign polyp 2. Early cancer 3. Superficial intramural lesions 4. Superficial mucosal lesions 5. Barrett's Oesophagus with dysplasia not suitable for other forms of endoscopic treatment/ surgery

Appropriate Filing of GI Endoscopy TOSP codes

On 30 Dec 2021, MOH issued a circular to remind all medical and dental practitioners on the appropriate utilisation of TOSP codes when making MediShield Life and MediSave claims for surgical procedures. Generally, it would be inappropriate to:

a. use proxy TOSP codes that do not accurately describe the procedure performed;
b. submit multiple TOSP codes for **a single surgical / procedural episode** of surgery or procedures consisting of multiple procedures that fall under a single TOSP code such as Whipple operation; and
c. perform and code sub-procedures as **separate surgical / procedural episodes** when all the procedures could be performed in a surgical episode and claimed under a single TOSP code. This constitutes to code-splitting.

2 To monitor and govern the TOSP filling and to ensure claims appropriateness, MOH has put together a list of **combination of GI Endoscopy related TOSP codes deemed to be inappropriate in Table 1 below.** Please note that the list serves as a reference and may be non-exhaustive. These rules will be adapted into the Claim Analytics System (CAS) to detect and flag inappropriate claims upfront to enable systematic claim adjudication.

Table 1: List of inappropriate pairing of GI Endoscopy related TOSP codes

Combo	TOSP code	Description	Rules
1	SF700I	Intestine/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions/ injection of varices/ removal of single polyp	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF701I (GI endoscopy) with SF700I (gastric polypectomy) in the same surgical/ procedural episode.
	SF701I	Intestine/ Stomach, Upper GI endoscopy with/ without biopsy	
2	SF808E	Oesophagus/ Stomach, Gastroscopy with therapy e.g., APC-Fulgarisation of tumour	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF701I (GI endoscopy with biopsy) with SF808E (Gastroscopy with Therapy) in the same surgical/ procedural episode.
	SF701I	Intestine/ Stomach, Upper GI endoscopy with/ without biopsy	

Combo	TOSP code	Description	Rules
3	SF702C	Colon, Colonoscopy, fibreoptic with/ without biopsy	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF702C (Colonoscopy) with SF704C and SF705C (colonoscopy with polypectomy) in the same surgical/ procedural episode.
	SF704C	Colon, Colonoscopy, fibreoptic with removal of polyp (single or multiple less than 1cm)	
	SF705C	Colon, Colonoscopy, fibreoptic with removal of polyps (Multiple more than 1cm)	
4	SF702C	Colon, Colonoscopy, fibreoptic with/ without biopsy	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim SF702C (Colonoscopy) together with SF710C and SF711C (sigmoidoscopy with/ without polypectomy) in the same surgical/ procedural episode.
	SF710C	Colon, Sigmoid, Sigmoidoscopy (flexible), Fibreoptic with/without biopsy	
	SF711C	Colon, Sigmoid, Sigmoidoscopy with polypectomy with biopsy	
5	SF700I	Intestine/Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions / injection of varices / removal of single polyp	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF700I with SF808E in the same surgical/ procedural episode.
	SF808E	Oesophagus/Stomach, Gastroscopy with therapy e.g., APC-Fulgarisation of tumour	
6	SF704C	Colon, Colonoscopy, fibreoptic with removal of polyp (single or multiple less than 1cm)	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF704C with SF705C in the same surgical/ procedural episode.
	SF705C	Colon, Colonoscopy, fibreoptic with removal of polyps (Multiple more than 1cm)	
7	SF710C	Colon, Sigmoid, Sigmoidoscopy (flexible), Fibreoptic with/without biopsy	Paragraph 2 of the MediSave Manual Annex A-5 states that only one TOSP code should be used if the code adequately describes the episode of surgery/ procedure carried out. It would be inappropriate to claim for both SF710C with SF711C in the same surgical/ procedural episode.
	SF711C	Colon, Sigmoid, Sigmoidoscopy with polypectomy with biopsy	