Annex B1 – Responses to General Feedback from GI Specialists

S/N	Feedback	MOH's Reply
1	Doctors must decide whether to allow the patient to make MediSave (MSV) claims at the point of offering the procedure, then counsel patients accordingly. First, we cannot adequately educate all the ward doctors on the detailed criteria (we allow internal medicine specialists to list the patient to reduce the number of obvious referrals such as GI bleed, dysphagia). Second, the counter staff have no access to patients' full medical history (such as their latest colonoscopy), and thus would not know (for the non-screening Table of Surgical Procedures (TOSPs)) whether the patients fulfil the criteria for claims. Third, most patients will want to try making a claim, even if the chance of approval is low. Thus, the endoscopist/ gastroenterologist/ surgeon ends up being the person to deny the patient from trying to claim MSV, as it risks the hospital losing money (if rejected) and the fee cannot be recovered from the patient. This interaction would strain the doctor-patient relationship.	Upon roll out, there will be a transition period post launch before the Claim Rules (CR) are enforced on 1 Apr 2023. Medical institutions should use this time to familiarise themselves of the Rules to ensure compliance. Any clarifications needed can be sent to claims_office_admin@moh.gov.sg. As the CR are developed in consultation with relevant specialists from both the public and private sectors and aligned with prevailing evidence-based literature, clinical practice and cost-effective guidelines, they should not impact a doctor's practices for a large majority of cases. Any existing clinical referral protocols should remain applicable, as CR have been verified to cover at least 95% of existing MediShield Life (MSHL) claims, based on past MediClaim data, where available. On management of patient requests for procedures that may not be medically necessary, please refer to paragraph 6 of the CR circular.
2	"Rules" are stricter than benchmarks or guidelines, which still account for clinical judgments. This is even more stringent than a guideline as it will affect clinical management and must be set up to accommodate every single exception. We should not have recommendations that are too tight because people who need scopes will be deprived of it. What is the system for adjudication? How efficient will this be? Will treatment be delayed due to the implementation of these rules?	The MSHL CR are developed in consult with relevant specialists from both public and private sectors and aligned with prevailing evidence-based literature, clinical practice and cost-effective guidelines. The rules have also been verified against past claims to ensure that that large majority of MSHL claims are covered. As such, CR should generally not incumber doctors' current practices. **The rules are also not absolute**, and doctors may deviate from the CR when they have a sound **clinical rationale** for doing so. Should such cases be picked up for adjudication by MOH, the doctor who submitted the claim will be approached for clarification on the rationale for deviation. The anonymised clinical information provided will be sent to a panel of 3 to 5 relevant specialists appointed by the MSHL Council for review. Claims will be allowed if the deviation is deemed medically necessary

		for the patient. If the panel disagrees with the clinical justifications provided, the doctor and his patient may, within 30 working days of receiving the panel's assessment, submit new clinical information to the panel for reconsideration. Any treatments or items assessed to be inappropriate will be rejected. Claim adjudication is a post-hoc audit of submitted MSHL claims a few months after the fact. As a context, MOH conducts risk-based audits - we will utilise system analytics, complaints and whistleblowing data to target higher-risk claims / deviations. Thus, **medically necessary treatment should not be delayed because of the implementation of CR or claim adjudication.**
3	Since MSV is a patient's own savings, why are we restricting the use of patient's MSV for their medical procedure?	If a MSHL claim has been assessed to be clinically inappropriate by the MSHL panel, MSV withdrawals for the claim will not be permitted. This safeguards MSV use for clinically necessary treatments.
4	Which health screening scopes are claimable by MSV but not by MSHL?	Colonoscopy as a screening procedure is claimable via MSV, as day procedure for patients aged 50 and above. This is expressly provided for in MSV. For details, please refer to https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/medisave.
5	Can the doctor collect the payment from the patient if they agree to pay in the event that the MSHL and MSV claim have been rejected?	It is possible for patients to request to proceed with procedures that are deemed inappropriate for the MSHL claim, but in such cases, doctor's practice must still comply with Singapore Medical Council's Ethical Code Ethical Guidance (ECEG) (e.g. an extra endoscope for an anxious patient). In such cases, proper clinical and financial counselling should be done, and the patient will have to bear the costs of the procedure. The doctor should ensure proper documentation of patient's decision to proceed with the treatment to pay out of pocket, after knowing that the treatment may not be MSHL claimable.

6	Will doctors have to perform pre-authorisation now for all cases?	The MSHL Act does not require pre-authorisation. Of note, MSHL pays for a smaller portion of the total private Bill. The Integrated Shield Plan (IP) insurers pay the larger portion and many offer pre-authorisation up to what is 'customary and reasonable' for a condition. As per current practice, doctors should continue to seek pre-authorisation from insurers for their cases, which will only impact the IP payout.
7	In a scenario where the patient provided incomplete or inaccurate information and the doctor lacks access to check on patient's medical history, if it was later found out that the procedure is not in compliant with the frequency stated in the CR, would the clinician be penalised for deviating from the CR? Would the procedure subsequently be deemed unnecessary and hence payment be rejected?	Doctors and claimants are allowed to put up a request to MOH to reconsider a case within 30 working days of the initial decision by the panel, if they felt that their MSHL claim was wrongfully rejected. Case notes documenting patient declared history would be part of the submissions requested for by the MSHL panel. The merits of each case will be weighed individually by the panel of appropriate specialists, based on the facts, circumstances and justifications provided. In this regard, even if a claim has deviated from the MSHL CR but had good clinical reasons for doing so, it will remain claimable under MSHL.
8	Would it not be more efficient to target the education of the 'errant' minority clinicians rather than apply a blunt tool which would impact the practice of the majority? A much more efficient approach would be to audit the minority of deviated claims, appoint a panel of specialists to review those flagged as doubtful procedures against the current clinical guidelines to determine if there is any dubious practice occurring leading to excessive procedures, and request the endoscopists to provide rationale for the deviation.	This is effectively the approach of CR and adjudication. The rules make it clear to all doctors the general standard to which cases would be audited and reviewed. We expect the majority of cases to be aligned with the CR given that it is developed by specialists from both private and public sector, taking reference from clinical practice guidelines. Further, past utilisation data from the MediClaim system, where available, show that minimally 95% of claims should go through. For the small number of deviated cases, they would be reviewed and given opportunity to justify to the MSHL Council appointed panel of specialists.
9	The committee should consider having a patient advocate to weigh in on the CR proposal as it would impact the patient's	As the CR document is rather technical, this consult is specifically for the specialists and insurers to provide their feedback to ensure

	clinical options, and thus be a matter of public concern.	professional consensus on the content of the CR. Today, doctors advise and discuss with patients the benefits, risk and cost of a treatment so that the patient can make an informed decision. This remains so and additionally make clear the general standard to which MSHL claims would be assessed.
10	These CR may be used by IP insurers and third-party administrators (without background medical knowledge) to inappropriately reject payments as they do not appreciate the unique clinical scenarios faced by clinicians. It is predictable that insurance companies will abuse these rules inflexibly to deny coverage, making medical practice unbearable and negative for patients.	Currently, without CR, IP insurers have a right to reject claims. The MSHL CR will therefore provide the clarity needed, in this case, that diagnostic scopes are allowed for specific clinical indications. CR are meant to guide the appropriateness of MSHL claims only, IP insurers can take reference from the CR where relevant. However, the IP insurer's assessment and payout decision will continue to be **independent and separate** from MOH's assessment, as these decisions are based on IP insurer's prevailing underwriting practices and IP contract terms and commercial considerations. Where insurers reject payout from IPs, they are expected to provide an explanation to the claimant on their own terms. IP policyholders/attending doctors who feel that they have been unjustifiably denied coverage on medical grounds may file a complaint against the insurer to the Clinical Claims Resolution Process (CCRP) at http://ccrp.com.sg/.
11	I do hope MOH does not just target gastroenterologists and surgeons who do scopes, but also look at the specialties that are violating the MOH fees guideline loophole.	The CR are focused on clinical procedures with high incidence of ambiguity, utilisation, and complaints from doctors and insurers. The GI CR was worked on first as there were debates in the public forum and in Parliament in 2020, whether GI diagnostic scopes were claimable from insurers. After GI CR, we will also be introducing CR for ENT scopes and related procedures, certain procedures in cardiology, orthopaedics, urology and ophthalmology,

		among others. MOH intends to roll out 2-3 sets of CR yearly in various specialty areas.
12	Are there any case studies for the medical community's better understanding?	Anonymised case studies of claims adjudicated as inappropriate and anomalous cases determined as appropriate will be shared with the clinical community for learning and reference purposes.

Annex B2 – Responses to Clinical Feedback from GI Specialists

S/N	TOSP code	Feedback	MOH's Reply
1	All codes in GI CR	*Frequency limitation related queries* • A scope every 3 years may be insufficient due to various factors – poor bowel prep, poor or inaccurate imaging, missed polyps, pathologies and tumours, different indications and new symptoms. How strict will the 3-year limit be enforced (2 year 9 months)? • For patients with previous cancers, why is there a limit on the number of years in which the patient can claim for OGDs? Follow-up of chronic medical problems by OGD and colonoscopy should be allowed without any pre-defined limitation of frequency. • When the patient has multiple colonic polyps and cannot be removed in one setting, the doctor may decide to repeat the procedure in a few weeks, this is not covered. • There should not be a duration assigned to haematochezia as patient may have haematochezia that could be due to colonic diverticular bleeding, rectal ulcer, rectal varices or other lesions that requires urgent colonoscopy and treatment. Bleeding in the GI tract often requires repeated procedures for diagnosis and treatment.	The time interval stated in the Claim Rules (CR) is meant for cases undergoing surveillance after a past primary pathology was found/treated. If a new symptom develops, a doctor can claim a scope to assess the new symptom, even if a previous scope has been done in the last 3 years. The CR have been amended to reflect this. CRs are not absolute and cannot possibly cover all clinical scenarios. Where repeat endoscopies are clinically required e.g. due to incomplete procedure, poor bowel prep or fresh bleeding, interval cancers etc., clinicians should proceed with these necessary procedures. Should the claim be picked up for panel assessment, the clinician should justify the medical rationale with clinical evidence to the panel (e.g. clinician could justify the need to re-scope due to poor bowel prep through providing Boston scores, American Society for Gastrointestinal Endoscopy (ASGE) quality indicators, photographic evidence of terminal ileum, or any other relevant indicators). Claims with valid clinical rationale accepted by the panel will still be approved.

		• Tenesmus is a sign of possible cancer. Why do we need to wait for 3 years? • Constipation as a change of bowel habit can be a sign of colonic stenosis. Constipation due to a stricture will respond to medical therapy but will recur. 3 years is arbitrary, and we question the evidence base for this. Interval cancers are well known despite colonoscopy screening and clinical judgment should be allowed for constipation and it should not be so restrictive. • In clinical practice, interval cancers have been seen within 3 years. Hence the general rule should be 2 years and not 3 years.	
2	All codes in GI CR	There should be inpatient access for patients who are psychologically in need of support in the preparation for endoscopy.	Generally, if there is valid rationale for deviation from the CR, the claim will still be approved, if the claim is picked for audit and the clinician able to justify the deviation on clinical grounds.
3	All codes in GI CR	<u>*Second opinion*</u> • What is meant by 'within 1 year for the same indication or by another specialist for a second opinion'? Does it imply that a patient seeing me for a second opinion not referred from a specialist is not eligible for a repeat gastroscopy if performed under a year ago?	The CR have been updated to allow for second opinions. This second opinion scope should be executed by a different doctor from the first one.

		• This restriction should only be applied to the endoscopist who had performed the previous colonoscopy. If the patient consults a second doctor for the same unresolved problem, the restriction should not apply.	
4	Colonoscopy codes in GI CR	*Indications for initial colonoscopy* Can the following conditions be added as indications for initial colonoscopy? (a) Unexplained weight loss (b) Positive FOBT/FIT (c) Search for primary cancer for known metastatic cancer where the primary cancer is not identified. (d) Un-investigated symptoms attributable to upper GI system *(currently appears in gastroscopy and should be replicated for colonoscopy)* (e) Lynch syndrome (f) Familial Adenomatous Polyposis (g) Other polyposis syndromes (h) Family history of colorectal cancer	S/N (a) to (g) have been added as indications for initial colonoscopy. S/N (h) is an indication for screening colonoscopy for primary prevention and thus not covered under MSHL and the CR. For more information, please refer to section 5.3 of the Jan 2020 Medisave Manual.
5	Colonoscopy codes in GI CR	Under surveillance (secondary) colonoscopy, can reassessment of a suspected incomplete colonic polypectomy be changed from 1 scope within 3 to 6 months after polypectomy to 1 scope within 6 weeks to 6 months?	The period for reassessment of a suspected incomplete colonic polypectomy has been amended to “within 6 months” in the CR.
6	Colonoscopy codes in GI CR	Regarding indications for initial colonoscopy, “mucus in stools for more than 2 weeks that do not respond to therapy of suspected underlying cause	The CR have been amended to remove mention of “more than 2 weeks that do not respond to therapy of suspected underlying cause” and “not responding to

		with no colonic imaging in the last 3 years for this indication", please specify the underlying causes that must be treated before allowing colonoscopy. Similarly, for "Tenesmus (incomplete bowel movement sensation) not responding to medical treatment with no colonic imaging in last 3 years", please specify what diagnosis should presumptively be treated before allowing colonoscopy.	medical treatment" respectively for clarity.
7	Colonoscopy codes in GI CR	What is the presumptive diagnosis to be treated in abdominal bloating or pain?	The presumptive diagnosis is the patient's previous diagnosis given when he presented with abdominal bloating or pain and was given a colonoscopy.
8	Colonoscopy codes in GI CR	*Management of IBD* • Patients with IBD require procedures for diagnosis and to assess adequate treatment response – mucosal and histologic, even when drug therapy is changed. This has not been allowed in the rules. • The colonoscopy picture and histology of patients with new onset IBD often evolves over the first 1-2 years after initial onset of symptoms. They are often initially nonspecific, becoming clearer on subsequent colonoscopy over 3-12 months. If subsequent colonoscopies are not permitted in patients who are found to have non-specific colitis or ileitis on index colonoscopy, we could end up with patients	The CR have been updated to include IBD related indications for endoscopy that more closely reflect clinical practice.

		who are more difficult and expensive to treat. • There may be a danger of over-diagnosing IBD if doctors are under pressure to make diagnosis based on non-specific data if there is no possibility of subsequent colonoscopies within a year. This exposes patients to potential drug adverse effects. • In the section on IBD surveillance rules, important indications for IBR endoscopic evaluation such as the role of endoscopic assessment for activity assessment (medical treatment planning, exclude opportunistic infection), and for endoscopic mucosal healing were missing. • A suggested approach for patients with ulcerative colitis would be to have repeat colonoscopies 3-6 months after treatment escalation, colonoscopies with biopsies 6-9 months to consider de-escalation and follow up evaluation in 3 months if dysplasia is detected in IBD patients. • For Crohn's disease, a suggested approach would be to have a colonoscopy 6 months after surgery to determine if treatment is adequate to prevent relapse, repeat colonoscopies 6-9 months after treatment escalation to further escalate if needed and follow up evaluation in	

		3 months if dysplasia is detected in IBD patients.	
9	SF700E, SF807E	How would one claim for BOTH dilatation and insertion of prosthesis? They are distinct procedures with distinct techniques and independent risks. What might happen is that an endoscopist may dilate and see the outcome and only insert a prosthesis if the situation isn't resolved. Two separate procedures, when in fact it may be done as one.	SF700E and SF807E have been removed from Table 1 of the CR document. Notwithstanding, MOH will continue to monitor the use of these 2 codes simultaneously.
10	Colonoscopy (screening)	Can increased screening be done for (a) Patients with rectal cancer and had a complete clinical response (b) HNPCC patients (c) Patients with MSI-H tumours (higher risk of metachronous cancers) (d) "Increased risk" group defined by STRC	S/N (a) to (c) are covered under surveillance (secondary) colonoscopy in SF702C. As CR are meant to manage MSHL claims, colonoscopy screening quotes (SF703C, SF706C, SF707C), which are not claimable under MSHL, have been removed from the CR.
11	Colonoscopy (screening)	As STRC guidelines advise screening every 5-10 years, may I suggest reducing the frequency permissible to 5 years instead of 10 years?	
12	Colonoscopy (screening)	In other jurisdictions, screening for colorectal cancer has reduced to 45 years due to a well-known trend of CRC appearing in younger patients. Why are we keeping to 50 years?	
13	OGD codes in GI CR	*Indications for gastroscopy* Can the following be considered as indications for administering a gastroscopy? (a) Abnormal tumour markers (b) Abnormal microRNA blood test result (ie GastroClear test, used for early detection of gastric cancer)	S/N (a) to (e) have been added to the initial indications for gastroscopy. S/N (i) has also been added to the indication for SF808E. S/N (f) can be claimed as subsequent scope under SF701I and SF700I.

		(c) Biopsy to obtain tissue for H.pylori culture in patients who repeatedly failed eradication therapy (d) Variceal screening (e) Eosinophilic oesophagitis or gastritis (diagnosis and treatment response, repeats may be needed within a few months of index gastroscopy) (f) Diagnosed gastric ulcer (8-12 weeks after diagnosis to assess healing and biopsy the scar) (g) Erosive oesophagitis (establish complete healing to downstage treatment, biopsy of red scars/columnar epithelium lined lower oesophagus after treatment so that inflammation does not interfere with the histological interpretation) (h) Food residue in stomach (despite adequate fasting) during index scope (repeat with longer fasting period) (i) Angiodysplasia particularly for SF808E	S/N (g) and (h) are too broad in nature and have not been added to the CR. Despite this, should doctors encounter situations as such where patient is clinically indicated for a gastroscopy, doctors should proceed with the procedure. The medical rationale could be provided to the panel during claim adjudication, should the claim be picked up for audit. Claims with valid clinical rationale accepted by the panel will still be approved.
14	SF700C	<u>Capsule endoscopy</u> • Suggest the sole criterion for capsule endoscopy to be investigation of symptoms attributable to the small bowel. • Can "Investigation of small bowel lesions found on imaging" be considered for capsule endoscopy?	The CR have been amended to include "investigation of small bowel lesions found on imaging". However, investigation of symptoms attributable to the small bowel should not be the only criterion for capsule endoscopy as it is too broadly worded and will not provide sufficient clarity.
15	SF701I	For achalasia, if after dilatation, symptoms either don't completely resolve or recur within 2 years, can a repeat scope KIV dilatation be claimed?	The CR have been amended to allow for this.
16	SF701I, SF700I	Patients should be allowed to continue claiming for surveillance scopes five years	After 5 years with no recurrence, surveillance scopes in these instances should only be claimed

		after their gastrectomy or treatment for oesophageal cancer.	when symptomatic or clinically indicated. Notwithstanding the above, for patients without any surgery, e.g. post definitive chemoradiotherapy or neoadjuvant chemoradiotherapy, or endoscopic treatment, and after the frequency allowed for first 5 years – 1 scope shall be claimable at 2 year intervals, for up to 20 years.
17	SF704E	Ablative treatment is used for vascular lesions, tumours and Barrett's oesophagus. The easier way to have a more enduring criteria is that the code is claimed when "ablation is required. "	Vascular lesions and tumours have been added as indications for SF704E in the CR. However, the statement "ablation is required" was not added as it is too broad and will not provide sufficient clarity.
18	TOSP	TOSPs can be more clearly defined for Percutaneous Enteral Gastrostomy (PEG) feeding tube insertion.	The TOSP committee will be amending the code descriptor for SF704S to keep to 'insertion' and introduce a new code for PEG/PEG change in the next round of updates.
19	TOSP	*Polyp size* • Are sizes defined in CR referencing the largest or the collective average of the polyps? E.g. If a patient has 20 polyps < 1cm, are they considered Table 3A or 3B? • Can we use a patient's histopathology report measurement when assessing polyp size? • There needs to be more clarity under TOSP SF700I on when this code should be used – possibly size and polyp morphology etc descriptors.	Comments have been surfaced to TOSP committee for review.
20	TOSP	Could we have clarity on codes to be used (SF702C or SF704C or SF701I or SF700I) in cases where tattooing for tumours is	Tattooing done during scopes can be claimed under SF702C or SF701I, unless other interventions are also performed.

		done during scopes prior to a definitive surgery.	
21	TOSP	As per our earlier clarification with TOSP-secy, SF701I (1B) would include -narrow band imaging and/or non-routine mapping biopsy of the stomach to detect intestinal metaplasia and/or digital chromatography examination and codes for lower GI scope would include extended ileoscopy as well. Could these points be clarified either in the codes or in your communication to the specialists.	These points have been added to the CR for clarity.
22	TOSP	There are legitimate procedures that do not have TOSP codes. Can we not charge these procedures at all? Perhaps the caveat is the phrase "do not accurately describe the procedure", so that if it reasonably accurately describes the procedure, then we can use a proxy code?	Kindly note that for a procedure to be included in the TOSP manual, the procedure should accrue sufficient evidence to demonstrate benefit and possess a good safety profile. If the use of proxy codes is required, TOSP Chair and TOSP comm members concurrence needs to be sought prior to its utilisation. The TOSP committee secretariat can be reach at tosp@moh.gov.sg.