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MINISTRY OF HEALTH
SINGAPORE

MediShield Life Claims Rules for Gastrointestinal Endoscopy and Related Procedures

CLAIMS MANAGEMENT OFFICE

AUGUST 2022
UPDATED MAY 2026

MediShield Life Claims Rules for Gastrointestinal (GI) Endoscopy and Related Procedures

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	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.
Day Surgery	A day surgery is defined as one in which the patient undergoes a surgical operation (with Table of Operation 1A to 7C; see Section 6 of the Manual on MediSave Scheme) or radiosurgery treatment, and who is admitted and discharged within 24 hours. This would not include inpatient admissions. How to interpret setting in CR? Where 'day surgery' is indicated, this means the procedure is predominantly claimed under the day surgery setting, including outpatient clinics, short stay units, and day surgery centres. CR may clarify conditions where inpatient claims may be made. Where 'inpatient/day surgery' is indicated, this means the procedure can be done in either inpatient or day surgery setting at the discretion of the medical practitioner.

General Comments

A. MediShield Life and Claims Rules

MediShield Life is a basic, universal national health insurance scheme that is supported by government funding and premiums paid by Singapore Citizens and Permanent 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 MediShield Life Claims Rules (CR) define parameters on what constitutes an appropriate claim under MediShield Life. The CR document is

(i) developed by Ministry of Health (MOH)-appointed workgroups comprising public and private sector specialists, in consultation with representative specialist groups;
(ii) based on published literature, prevailing clinical practice, cost-effective guidelines; and
(iii) verified against available past claims data to ensure that they cover the vast majority of claims that are medically appropriate.

3 The CR document is **not** a clinical practice guideline. The objective of the rules is to make clear to all medical practitioners the general standard to which cases would be audited and reviewed.

4 The CR is not exhaustive. Deviation from CR is allowed if clinically justified. The treating medical practitioner should inform his patient of the deviation, perform relevant documentation, and be prepared to provide justification if queried.

5 Procedures commonly done in a day surgery setting should be claimed as day surgery where possible. Notwithstanding, for such procedures, the CR includes a non-exhaustive list of conditions where inpatient claims may be allowed. In addition to standard exclusions under MediShield Life (found here), scenarios which are not claimable in general include:

(i) admissions based on the request of a patient, without evidence of clinical necessity;
(ii) tests conducted for primary prevention[1] including general medical/ health screening packages, physical check-ups, and vaccinations;
(iii) procedures done for cosmetic purposes. Exceptions to this include cosmetic surgery to reconstruct a body part, particularly face and neck, where that part (physical appearance or function) has been affected by trauma, cancer, congenital anomalies, nerve palsies and other disfiguring diseases (to be ascertained by pre-surgical photographs). Medical practitioners are expected to exercise good clinical judgement in determining if a procedure is cosmetic in nature. If audited, medical practitioners must be prepared to justify their decision.

[1] 'Primary prevention' refers to medical services for generally healthy individuals to pick up asymptomatic disease early, in the absence of medical indications.

B. How to use the Claims Rules

Each set of CR is based on a subset of specialty-specific Table of Surgical Procedures (TOSP) codes. These are priority areas identified as procedures with high volume of claims; and where there were ambiguities. This list is non-exhaustive, and claims containing codes not mentioned in this CR document may still be subject to adjudication by MOH. Claims can be adjudicated based on:

(i) accepted standards of medical practice (peer reviewed journals, MOH Clinical Practice Guidelines (CPG), Agency for Care Effectiveness's (ACE) Guidances (ACG), consensus statements, peer concurrences); and

(ii) prevailing guidelines published by MOH and its appointed agencies, such as the TOSP Booklet, Manual on MediSave/ MediShield Life claims, Terms and Conditions for Approval under MediSave/ MediShield Life schemes, MOH Finance Circulars related to MediShield Life claims, MediShield Life CR where available and Singapore Medical Council (SMC)'s Ethical Code and Ethical Guidelines (ECEG).

2 The TOSP codes in this CR are arranged by anatomical parts (e.g. colon, stomach, bile duct/gallbladder). MediShield Life CR aim to provide additional clarity to guide an appropriate claim in the following areas:

(i) Clinical indications
(ii) Setting (Day surgery or Inpatient)
(iii) Frequency of claims allowed, where applicable
(iv) Appropriate TOSP coding; and
(v) In certain cases, modality of treatment allowed under the TOSP code (e.g. Instances where "technology-assisted" surgical treatments are claimable).

3 These rules work in tandem with the Guidelines on MediSave/ MediShield claims as well as the general TOSP coding principles in the TOSP booklet to guide appropriate coding practices.

4 Registered doctors may claim 1 non-core Continuing Medical Education (CME) point under category 3A for reading each set of CR and its accompanying case studies found at the Claims Management webpage.

Yours Sincerely,

Dr Ho Kok Sun

Chairman

On behalf of the Claims Rules for Gastrointestinal Endoscopy Workgroup, comprising:

(In Alphabetical Order)

Assoc Prof Asim Shabbir	Dr Chua Tju Siang
Clin Prof Ang Tiing Leong	Dr Ho Kok Sun
Dr Chong Siong Eng Roland	Dr How Kwang Yeong

Section 1 : Existing codes

Colonoscopy Claims Rules

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF702C	**2C**	COLON, COLONOSCOPY, FIBREOPTIC WITH/WITHOUT BIOPSY	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for acute abdominal conditions 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: a. Extensive endoscopic mucosal resection b. Endoscopic submucosal dissection c. Endoscopic full thickness resection	**This procedure may be claimed according to the rules below:** **Initial colonoscopy** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Melaena after upper GI causes have been excluded c. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no colonoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 11. Faecal incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF702C</td><td>2C</td><td>COLON, COLONOSCOPY, FIBREOPTIC WITH/WITHOUT BIOPSY</td><td>7. Endoscopic dilatation of GI stricture
8. Frail/elderly/paediatric patients for bowel preparation
9. 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</td><td>12. Suspected foreign body in colon/ rectum
13. Unexplained anaemia
14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
15. Raised faecal Calprotectin with abdominal symptoms in patient with suspected inflammatory bowel disease
16. Persistent proctalgia with red flag symptoms for more than 4 weeks
17. Palpable mass on physical examination (abdominal examination/ digital rectal examination)
18. Hereditary Nonpolyposis Colorectal Cancer Syndrome
19. Familial Adenomatous Polyposis and other hereditary polyposis syndromes

Subsequent colonoscopy for same or different clinical indication from previous colonoscopy
1. Megacolon decompression
2. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
3. Persistent hematochezia (including even if colonoscopy is done in the same admission)
4. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) colonoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

<table>
<tr><th>SN</th><th>Clinical indication</th><th>Frequency</th></tr>
<tr><td>1</td><td>Patients with an incomplete colonic assessment before colonic resection for colorectal cancer</td><td>1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment</td></tr>
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TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)		
SF702C	**2C**	COLON, COLONOSCOPY, FIBREOPTIC WITH/WITHOUT BIOPSY		2	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				3	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
				4	Personal history of colorectal polyps with malignant potential (post polypectomy)	1 to 3 years after polypectomy in the presence of high-risk features; otherwise, 3 to 5 years after polypectomy for low-risk polyps
				5	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				6	Patients with a history of rectal cancer who achieved a complete	1 scope at 1 year following completion of neoadjuvant therapy

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF702C	**2C**	COLON, COLONOSCOPY, FIBREOPTIC WITH/WITHOUT BIOPSY		clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a "watch-and-wait" approach **Same-sitting upper GI endoscopy and colonoscopy/ sigmoidoscopy** 1. Cancer of unknown origin 2. Investigation for unexplained anaemia 3. Indications fulfilling both upper and lower GI endoscopy

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF704C	**3A**	COLON, COLONOSCOPY, FIBREOPTIC WITH REMOVAL OF POLYP (S) (SINGLE OR MULTIPLE LESS THAN 1CM)[2], WITH/WITHOUT HAEMOSTASIS[3]	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for acute abdominal conditions 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: a. Extensive endoscopic mucosal resection b. Endoscopic submucosal dissection c. Endoscopic full thickness resection 7. Endoscopic dilatation of GI stricture 8. Frail/elderly/paediatric patients for bowel preparation 9. In general, where patient has medical comorbidities requiring	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with single or multiple polyps less than 1cm removed** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Melaena after upper GI causes have been excluded c. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no colonoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 11. Faecal incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 12. Suspected foreign body in colon/rectum 13. Unexplained anaemia 14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)

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16. Persistent proctalgia with red flag symptoms for more than 4 weeks
17. Palpable mass on physical examination (abdominal examination/ digital rectal examination)
18. Hereditary Nonpolyposis Colorectal Cancer Syndrome
19. Familial Adenomatous Polyposis and other hereditary 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. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
3. Recurrent hematochezia (including even if colonoscopy is done in the same admission)
4. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) colonoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)
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<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Personal history of colorectal polyps with malignant potential</td><td>1 to 3 years after polypectomy in the presence of high-risk features; otherwise, 3 to 5 years after polypectomy for low-risk polyps</td></tr>
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SF704C	**3A**	COLON, COLONOSCOPY, FIBREOPTIC WITH REMOVAL OF POLYP (S) (SINGLE OR MULTIPLE LESS THAN 1CM) [2], WITH/WITHOUT HAEMOSTASIS[3]		3	Patients with an incomplete colonic assessment before colonic resection for colorectal cancer	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				5	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 b. Intermediate risk features: extensive colitis with mild/moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age
				6	Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were	1 scope at 1 year following completion of neoadjuvant therapy

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TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF705C	**3B**	COLON, COLONOSCOPY, FIBREOPTIC WITH REMOVAL OF POLYPS (MULTIPLE MORE THAN 1CM), WITH/WITHOUT HAEMOSTASIS[4]	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for acute abdominal conditions 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: a. Extensive endoscopic mucosal resection b. Endoscopic submucosal dissection c. Endoscopic full thickness resection 7. Endoscopic dilatation of GI stricture 8. Frail/elderly/paediatric patients for bowel preparation 9. In general, where patient has medical comorbidities requiring	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with multiple polyps more than 1cm removed** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Melaena after upper GI causes have been excluded c. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no colonoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 11. Faecal incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 12. Suspected foreign body in colon/rectum 13. Unexplained anaemia 14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)

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16. Persistent proctalgia with red flag symptoms for more than 4 weeks
17. Palpable mass on physical examination (abdominal examination/ digital rectal examination)
18. Hereditary Nonpolyposis Colorectal Cancer Syndrome
19. Familial Adenomatous Polyposis and other hereditary polyposis syndromes

Subsequent colonoscopy for same or different clinical indication from previous colonoscopy with multiple polyps more than 1cm removed
1. Megacolon decompression
2. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
3. Recurrent hematochezia (including even if colonoscopy is done in the same admission)
4. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) colonoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)
<table><tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr><tr><td>1</td><td>Personal history of colorectal polyps with malignant potential</td><td>1 to 3 years after polypectomy in the presence of high-risk features; 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></table></td></tr>
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SF705C	**3B**	COLON, COLONOSCOPY, FIBREOPTIC WITH REMOVAL OF POLYPS (MULTIPLE MORE THAN 1CM), WITH/WITHOUT HAEMOSTASIS[4]		3	Patients with an incomplete colonic assessment before colonic resection for colorectal cancer	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				5	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 b. Intermediate risk features: extensive colitis with mild/ moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age
				6	Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a “watch-and-wait” approach	1 scope at 1 year following completion of neoadjuvant therapy

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF705C	**3B**	COLON, COLONOSCOPY, FIBREOPTIC WITH REMOVAL OF POLYPS (MULTIPLE MORE THAN 1CM), WITH/WITHOUT HAEMOSTASIS[4] [4] Haemostasis includes adrenaline injection, clip(s) application, argon plasma coagulation, and haemospray.		**Same-sitting upper GI endoscopy and colonoscopy/ sigmoidoscopy** 1. Cancer of unknown origin 2. Investigation for unexplained anaemia 3. Indications fulfilling both upper and lower GI endoscopy

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF708C	**3C**	COLON, COLONOSCOPY WITH ENDOSCOPIC MUCOSAL RESECTION (EMR) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[5]	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm)*** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Melaena after upper GI causes have been excluded c. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no colonoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 11. Faecal incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 12. Suspected foreign body in colon/rectum

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14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
15. Raised faecal Calprotectin with abdominal symptoms in patient with suspected inflammatory bowel disease
16. Persistent proctalgia with red flag symptoms for more than 4 weeks
17. Palpable mass on physical examination (abdominal examination/digital rectal examination)
18. Hereditary Nonpolyposis Colorectal Cancer Syndrome
19. Familial Adenomatous Polyposis and other hereditary polyposis syndromes
20. A repeat colonoscopy for polyps that cannot be removed by conventional polypectomy

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. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
4. Recurrent hematochezia (including even if colonoscopy is done in the same admission)
5. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) colonoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

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SF708C	**3C**	COLON, COLONOSCOPY WITH ENDOSCOPIC MUCOSAL RESECTION (EMR) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[5]		1	Personal history of colorectal polyps with malignant potential	1 to 3 years after polypectomy in the presence of high-risk features; otherwise, 3 to 5 years after polypectomy for low-risk polyps
				2	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				3	Patients with an incomplete colonic assessment before colonic resection for colorectal cancer	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				4	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
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<tr><td>6</td><td>Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a “watch-and-wait” approach</td><td>1 scope at 1 year following completion of neoadjuvant therapy</td></tr>
</table>

* The general recommendation is for the standard polypectomy codes (SF704C and SF705C) to be utilised when polyps are less than 3cm. However, ESD/ EMR may be used for small polyp <3cm not effectively removed by standard snare polypectomy e.g. neuroendocrine lesions (higher risk of positive deep margins on snare polypectomy) or lesions which are very flat or in odd locations (e.g., behind a fold, odd angle). In these cases, the surgeon may use SF708C/ SF807C with supporting evidence provided within the procedure notes (i.e. clear description of the indication for requiring ESD/ EMR with adequate documentation)</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF710C	**1B**	COLON, SIGMOID, SIGMOIDOSCOPY (FLEXIBLE), FIBREOPTIC WITH/WITHOUT BIOPSY	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for acute abdominal conditions 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: a. Extensive endoscopic mucosal resection b. Endoscopic submucosal dissection c. Endoscopic full thickness resection 7. Endoscopic dilatation of GI stricture 8. Frail/elderly/paediatric patients for bowel preparation 9. In general, where patient has medical comorbidities requiring peri-procedural resuscitation, management, monitoring	**This procedure may be claimed according to the rules below:** **Initial sigmoidoscopy** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Haematochezia (fresh red blood per rectum) with no sigmoidoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no sigmoidoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no sigmoidoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF710C</td><td>1B</td><td>COLON, SIGMOID, SIGMOIDOSCOPY (FLEXIBLE), FIBREOPTIC WITH/WITHOUT BIOPSY</td><td>and treatment in an inpatient setting e.g., hepatic, cardiac, renal failure, frailty</td><td>11. Faecal incontinence if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years
12. Suspected foreign body in rectum
13. Unexplained anaemia
14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
15. Persistent proctalgia with red flag symptoms for more than 4 weeks
16. Palpable mass on physical examination (abdominal examination/ digital rectal examination)
17. Hereditary Nonpolyposis Colorectal Cancer Syndrome
18. Familial Adenomatous Polyposis and other hereditary polyposis syndromes

Subsequent sigmoidoscopy for same or different clinical indication from previous sigmoidoscopy
1. Megacolon decompression
2. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
3. Recurrent hematochezia (including even if colonoscopy is done in the same admission)
4. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) sigmoidoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

<table><tr><th>SN</th><th>Clinical indication</th><th>Frequency</th></tr></table></td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)		
SF710C	**1B**	COLON, SIGMOID, SIGMOIDOSCOPY (FLEXIBLE), FIBREOPTIC WITH/WITHOUT BIOPSY		1	Patients with an incomplete colonic assessment before colonic resection for colorectal cancer	1 scope within 3-12 months after surgery: Endoscopy should be performed soon after the patient recovers from treatment
				2	Personal history of colorectal polyps with malignant potential	1 to 3 years after polypectomy in the presence of high-risk features; otherwise, 3 to 5 years after polypectomy for low-risk polyps
				3	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				4	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				5	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

<table>
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<tr><td>SF710C</td><td>1B</td><td>COLON, SIGMOID, SIGMOIDOSCOPY (FLEXIBLE), FIBREOPTIC WITH/WITHOUT BIOPSY</td><td></td><td>
<table>
<tr><td></td><td></td><td>mild/moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age</td></tr>
<tr><td>6</td><td>Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a “watch-and-wait” approach</td><td>1 scope every 3 to 6 monthly for the first 2 years, followed by 6 monthly for the next 3 years</td></tr>
</table>

Same-sitting upper GI endoscopy and colonoscopy/ sigmoidoscopy
1. Cancer of unknown origin
2. Investigation for unexplained anaemia
3. Indications fulfilling both upper and lower GI endoscopy</td></tr>
</table>

Oesophagogastroduodenoscopy (OGD) Claims Rules

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF701I	**1B**	INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH/WITHOUT BIOPSY[6]	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for gastroscopy for acute symptoms 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Treatment of oesophageal varices 7. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as a. extensive endoscopic mucosal resection b. endoscopic submucosal dissection c. endoscopic full thickness resection 8. In general, where patient has medical co-morbidities requiring peri-procedural resuscitation, management, monitoring and	**This procedure may be claimed according to the rules below:** **Initial gastroscopy** 1. Evaluation of dyspepsia for more than 2 weeks or relapses after cessation of treatment 2. Unexplained anorexia and weight loss 3. Evaluation of dysphagia 4. Reflux symptoms which are uninvestigated/ odynophagia 5. Upper GI bleed (active or recent) 6. Chronic blood loss (FOBT/ FIT positive) 7. Unexplained anaemia 8. Acute injury after caustic ingestion 9. Abnormal imaging - thickened folds/ mass on radiology 10. Assessment before and after bariatric surgery 11. Assessment before and after oesophageal surgery 12. 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 13. Abnormal tumour markers (includes CA19-9, CEA) 14. Abnormal microRNA blood test result (e.g. GastroClear test) 15. Biopsy to obtain tissue from *H. Pylori* culture in patients that have failed eradication therapy at least twice 16. Variceal screening in patients with liver cirrhosis or fibrosis 17. Hereditary nonpolyposis colorectal cancer syndrome/ polyposis syndromes 18. Assessment for foreign bodies 19. Assessment for oesophageal perforation 20. Bariatric surgery complications including weight regain, dumping syndrome, or other side effects related to primary bariatric surgery 21. Assessment before or after endoscopic sleeve gastroplasty

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF701I</td><td>1B</td><td>INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH/WITHOUT BIOPSY[6]</td><td>treatment in an inpatient setting e.g. hepatic, cardiac, renal failure, frailty</td><td>22. Perioperative upper gastrointestinal procedures
23. Paraneoplastic workup (GED, cutaneous vasculitidis etc)

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>
<tr><td>2</td><td>Reassess previous gastric ulcer healing to exclude malignancy</td><td>Within 8-12 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 endoscopic 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>
<tr><td>6</td><td>Reassessment for second opinion or biopsy</td><td>Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF701I</td><td>1B</td><td>INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH/WITHOUT BIOPSY[6]</td><td></td><td>
<table>
<tr><td>7</td><td>Eosinophilic oesophagitis</td><td>As needed after adding a food or food group back for 6-8 weeks</td></tr>
<tr><td>8</td><td>Eosinophilic gastritis</td><td>As needed</td></tr>
</table>
Surveillance (Secondary) Gastroscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)
<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>Atypia/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.
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
c. Where there is high-grade dysplasia, a scope may be repeated in 3 months</td></tr>
<tr><td>5</td><td>Achalasia</td><td>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</td></tr>
<tr><td>6</td><td>History of caustic ingestion</td><td>1 scope every 2 or 3 years</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th colspan="3">Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF701I</td><td>1B</td><td>INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH/WITHOUT BIOPSY[6]

[6] Screening gastroscopy is not MediSave/MediShield Life claimable.</td><td></td><td colspan="3"><table>
<tr><td>7</td><td>Hereditary Nonpolyposis Colorectal Cancer Syndrome</td><td>1 scope every 2-3 years from 30-35 years old onwards</td></tr>
<tr><td>8</td><td>Polyposis Syndrome</td><td>Polyps larger than 1 cm performed yearly/ polyps <1 cm performed every 2 to 3 years</td></tr>
<tr><td>9</td><td>History of sporadic adenomas</td><td>1 scope may be claimed 1 year after resection of adenomatous or dysplastic polyps in stomach</td></tr>
<tr><td>10</td><td>Previous gastrectomy (non-bariatric)</td><td>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</td></tr>
<tr><td>11</td><td>Pernicious anaemia</td><td>1 scope every 2 or 3 years</td></tr>
<tr><td>12</td><td>Atrophic gastritis</td><td>1 scope every 2 or 3 years</td></tr>
<tr><td>13</td><td>Liver cirrhosis</td><td>a. Patients with advanced (decompensated) liver cirrhosis and found to have no varices on initial screening endoscopy but has a platelet count of less than 150,000/µL may claim first scope within 6 months from time of diagnosis and 2 yearly thereafter
b. Patients with advanced (decompensated) liver cirrhosis, found to have small varices on initial screening endoscopy, and a platelet count of less than 150,000/µL may claim first scope within 6 months from time of diagnosis and yearly thereafter</td></tr>
</table></td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)		
				14	Previous treatment for oesophageal cancer	a. Where chemo-radiotherapy had been performed with a complete response without oesophagectomy, 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 (oesophagectomy) had been performed, a scope may be claimed at 1, 3, 5 years post therapy
				15	Post-resection surveillance for upper gastrointestinal cancer	As needed

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF700I	**2C**	OESOPHAGUS/STOMACH, UPPER GI ENDOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS/ INJECTION OF VARICES/ REMOVAL OF SINGLE POLYP	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for gastroscopy for acute symptoms 2. Patient with medical comorbidities that require pre/ post procedural management and monitoring 3. Symptomatic anaemia 4. Acute GI bleeding 5. Management of acute abdominal pain, 6. Suspected intestinal obstruction/ subacute intestinal obstruction 7. Treatment of oesophageal varices 8. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as a. extensive endoscopic mucosal resection	**This procedure may be claimed according to the rules below:** **Initial gastroscopy** 1. Uninvestigated symptoms attributable to upper GI system 2. Evaluation of dyspepsia for more than 2 weeks or relapses after cessation of treatment 3. Unexplained anorexia and weight loss 4. Evaluation of dysphagia/ odynophagia 5. Upper GI bleed (active or recent) 6. Chronic blood loss (FOBT/ FIT positive) 7. Unexplained anaemia 8. Abnormal imaging - thickened folds/ mass on radiology 9. History of known varices (scheduled eradication) 10. Lesions identified during diagnostic gastroscopy such as polyps 11. Foreign body 12. 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 13. Abnormal tumour markers (includes CA19-9, CEA) 14. Abnormal microRNA blood test result (e.g., GastroClear test) 15. Biopsy to obtain tissue from *H. Pylori* culture in patients that have failed eradication therapy at least twice 16. Variceal screening in patients with liver cirrhosis or fibrosis 17. Hereditary nonpolyposis colorectal cancer syndrome/ polyposis syndromes 18. Assessment for foreign bodies 19. Assessment for oesophageal perforation 20. Bariatric surgery complications including weight regain, dumping syndrome, or other side effects related to primary bariatric surgery 21. Assessment before or after endoscopic sleeve gastroplasty 22. Perioperative upper gastrointestinal procedures

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<tr><td>SF700I</td><td>2C</td><td>OESOPHAGUS/STOMACH, UPPER GI ENDOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS/ INJECTION OF VARICES/ REMOVAL OF SINGLE POLYP</td><td>b. endoscopic submucosal dissection
c. endoscopic full thickness resection
9. 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>23. Paraneoplastic workup (GED, cutaneous vasculitidis etc)

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>
<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>
<tr><td>6</td><td>Reassessment for planned treatment</td><td>Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy</td></tr>
<tr><td>7</td><td>Eosinophilic oesophagitis</td><td>As needed after adding a food or food group back for 6-8 weeks</td></tr>
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<tr><td>SF700I</td><td>2C</td><td>OESOPHAGUS/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>Surveillance (Secondary) Gastroscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

<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>
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<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
b. Where there is indefinite dysplasia or low-grade dysplasia for which no intervention is done, a scope may be repeated in 6 months
c. Where there is high-grade dysplasia, a scope may be repeated in 3 months</td></tr>
<tr><td>5</td><td>Achalasia</td><td>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</td></tr>
<tr><td>6</td><td>History of caustic ingestion</td><td>1 scope every 2 or 3 years</td></tr>
</table>
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</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)		
SF700I	**2C**	OESOPHAGUS/STOMACH, UPPER GI ENDOSCOPY WITH POLYPECTOMY/ REMOVAL OF FOREIGN BODY/DIATHERMY OF BLEEDING LESIONS/ INJECTION OF VARICES/ REMOVAL OF SINGLE POLYP		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, 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
				14	Previous treatment for oesophageal cancer	a. Where chemo-radiotherapy had been performed with a complete response without oesophagectomy, 1 scope may be claimed i. every 3 months for the first 2 years,

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th colspan="3">Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>ii. every 6 months thereafter in the 3rd year, and
iii. annually in the 4th and 5th year
b. Where chemotherapy and surgery (oesophagectomy) had been performed, a scope may be claimed at 1, 3, 5 years post therapy</td></tr>
<tr><td></td><td></td><td></td><td></td><td>15</td><td>Post-resection surveillance for upper gastrointestinal cancer</td><td>As needed</td></tr>
</table>

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF700C</td><td>3A</td><td>CAPSULE ENDOSCOPY</td><td>Day surgery

Claims can be made for the inpatient setting provided they fulfil one of the following conditions (including but not limited to):
1. Emergency admission for acute symptoms
2. Obscure GI bleeding
3. 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:

1. Repeat discrete episodes of obscure GI bleeding
2. Investigation of small bowel pathology (e.g. anaemia, bleeding, pain, tumour)
3. Investigation of small bowel lesions found on imaging

<table><tr><th>SN</th><th>Conditions</th><th>Frequency of claims for capsule endoscopy</th></tr><tr><td>1</td><td>Investigation of:
a. Anaemia
b. Abdominal pain</td><td>As needed</td></tr></table>
The procedure may be claimed together with another upper gastrointestinal endoscopic procedure in cases such as the following:
1. Investigation of occult anaemia
2. Patients with swallowing difficulties
3. Other indications for a pan-endoscopic evaluation</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF704E	**3A**	OESOPHAGUS/ STOMACH/COLON, GASTROINTESTINAL ENDOSCOPY, ABLATIVE TREATMENT	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for gastroscopy for acute symptoms 2. 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 4. Endoscopic ablation of post-bariatric surgery anatomy, i.e dilatation of gastrojejunostomy

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF705E	**3C**	OESOPHAGUS/ INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH ENDOSCOPIC SUBMUCOSAL DISSECTION	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below.** **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 **Frequency:** **This procedure may be claimed up to twice a year. SF701I could be claimed within a year following SF705E as a follow-up procedure.** ** Please note that SF701I performed prior to ESD (SF705E) at a different surgical / procedural episode is claimable.

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF807E	**3A**	UPPER/LOWER GI, ENDOSCOPY/IMAGING GUIDED STENT PLACEMENT	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** **Upper GI indications** 1. Palliation of malignant dysphagia/ upper GI cancer 2. Obstruction/ strictures 3. Anastomotic leakage 4. Fistula 5. Perforation/ rupture 6. Uncontrolled/ variceal bleeding 7. Insertion of prosthesis **Lower GI indications** 1. As a bridge to surgery in malignant colonic obstruction 2. Palliation of malignant colonic obstruction 3. Anastomotic leakage 4. Strictures 5. Fistula

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF808E	**3A**	OESOPHAGUS/STOMACH, GASTROSCOPY WITH THERAPY E.G. APC-FULGARISATION OF TUMOUR	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for gastroscopy for acute symptoms 2. 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	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/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	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for gastroscopy for acute symptoms 2. 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/ adenomatous 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

Section 2: New codes

Colonoscopy Claims Rules

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF807C	**4A**	COLON, COLONOSCOPY WITH ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[7]	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** **Initial colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm)*** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Melaena after upper GI causes have been excluded c. Haematochezia (fresh red blood per rectum) with no colonoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no colonoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no colonoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF807C	**4A**	COLON, COLONOSCOPY WITH ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[7]		11. Faecal incontinence if there is no colonic mucosal assessment (colonoscopy or CT colonography) of adequate quality in the previous 5 years 12. Suspected foreign body in colon/ rectum 13. Unexplained anaemia 14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125) 15. Raised faecal Calprotectin with abdominal symptoms in patient with suspected inflammatory bowel disease 16. Persistent proctalgia with red flag symptoms for more than 4 weeks 17. Palpable mass on physical examination (abdominal examination/ digital rectal examination) 18. Hereditary Nonpolyposis Colorectal Cancer Syndrome 19. Familial Adenomatous Polyposis and other polyposis syndromes 20. A repeat colonoscopy for polyps that cannot be removed by conventional polypectomy **Subsequent colonoscopy for same or different clinical indication from previous colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm)** 1. Megacolon decompression 2. Therapeutic treatment of polyps that were previously not removed 3. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing 4. Recurrent hematochezia (including even if colonoscopy is done in the same admission) 5. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF807C</td><td>4A</td><td>COLON, COLONOSCOPY WITH ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[7]</td><td></td><td>Surveillance (Secondary) colonoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

<table>
<tr><th>SN</th><th>Conditions</th><th>Frequency</th></tr>
<tr><td>1</td><td>Personal history of colorectal polyps with malignant potential</td><td>1 to 3 years after polypectomy in the presence of high-risk features; 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>
<tr><td>3</td><td>Patients with an incomplete colonic assessment before colonic resection for colorectal cancer</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>4</td><td>Personal history of colorectal malignancy</td><td>Every 1 to 3 years starting from 1 year after resection</td></tr>
<tr><td>5</td><td>Personal history of IBD</td><td>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:

c. High risk features: extensive colitis with severe active inflammation, stricture or dysplasia detected in the</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th colspan="3">Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td>SF807C</td><td>4A</td><td>COLON, COLONOSCOPY WITH ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) OF LARGE POLYPS (>3CM), WITH/WITHOUT HAEMOSTASIS[7]

[7] Haemostasis includes adrenaline injection, clip(s) application, argon plasma coagulation, and haemospray.</td><td></td><td colspan="3">
<table>
<tr><td></td><td></td><td>last 5 years, PSC, CRC in first-degree relative <50 years of age
d. Intermediate risk features: extensive colitis with mild/ moderate active inflammation, pseudopolyps, CRC in first-degree relative >50 years of age</td></tr>
<tr><td>6</td><td>Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a “watch-and-wait” approach</td><td>1 scope at 1 year following completion of neoadjuvant therapy</td></tr>
</table>

*The general recommendation is for the standard polypectomy codes (SF704C and SF705C) to be utilised when polyps are less than 3cm. However, ESD/ EMR may be used for small polyps <3cm not effectively removed by standard snare polypectomy e.g. neuroendocrine lesions (higher risk of positive deep margins on snare polypectomy) or lesions which are very flat or in odd locations (e.g., behind a fold, odd angle). In these cases, the surgeon may use SF708C/ SF807C with supporting evidence provided within the procedure notes (i.e. clear description of the indication for requiring ESD/ EMR with adequate documentation)</td></tr>
</table>

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
SF711C	**1C**	COLON, SIGMOID, SIGMOIDOSCOPY WITH POLYPECTOMY WITH BIOPSY	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Emergency admission for acute abdominal conditions 2. Symptomatic anaemia 3. Acute GI bleeding 4. Management of acute abdominal pain 5. Suspected intestinal obstruction/ subacute intestinal obstruction 6. Post-endoscopic resection of GI neoplasia when advanced techniques with higher risks of complications are used, such as: a. Extensive endoscopic mucosal resection	**This procedure may be claimed according to the rules below:** **Initial sigmoidoscopy** 1. Lower GI bleeding: a. Positive Faecal Occult Blood Test (FOBT)/ Faecal Immunochemical Test (FIT) b. Haematochezia (fresh red blood per rectum) with no sigmoidoscopy in the last 3 years for this indication 2. Unintended weight loss 3. Metastatic adenocarcinoma where the primary cancer is not identified 4. 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 5. Constipation with alarm symptoms 6. Mucus in stools with no sigmoidoscopy in the last 3 years for this indication 7. Tenesmus (incomplete bowel movement sensation) with no sigmoidoscopy in last 3 years for this indication 8. Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy or relapses on cessation of medical therapy with no colonoscopy in the last 3 years, unless specifically medically justified and documented 9. Suspected colonic pathology on radiologic imaging 10. Rectal prolapse if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years 11. Faecal incontinence if there is no colonic mucosal assessment (sigmoidoscopy or CT colonography) of adequate quality in the previous 5 years 12. Suspected foreign body in rectum 13. Unexplained anaemia

<table>
<tr><th>TOSP Code</th><th>Table Code</th><th>TOSP Description</th><th>Claims Indicators (Setting)</th><th>Claims Indicators (Clinical Indications/Frequency)</th></tr>
<tr><td></td><td></td><td></td><td>b. Endoscopic submucosal dissection
c. Endoscopic full thickness resection
7. Endoscopic dilatation of GI stricture
8. Frail/ elderly/paediatric patients for bowel preparation
9. 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</td><td>14. Elevated serum tumour marker, suspicious for colorectal pathology (includes CEA, CA19-9, CA125)
15. Persistent proctalgia with red flag symptoms for more than 4 weeks
16. Palpable mass on physical examination (abdominal examination/ digital rectal examination)
17. Hereditary Nonpolyposis Colorectal Cancer Syndrome
18. Familial Adenomatous Polyposis and other polyposis syndromes

Subsequent sigmoidoscopy for same or different clinical indication from previous sigmoidoscopy
1. Megacolon decompression
2. Inflammatory Bowel Disease (IBD) – after initiation of and response to medical treatment for endoscopic evidence of healing
3. Recurrent hematochezia (including even if colonoscopy is done in the same admission)
4. Reassessment for planned treatment - Where needed, a repeat scope may be claimed for a second opinion on suitability of endoscopic resection or biopsy/re-biopsy

Surveillance (Secondary) sigmoidoscopy
(Surveillance scopes for pre-malignant and malignant conditions shall be continued lifelong)

<table>
<tr><th>SN</th><th>Clinical indication</th><th>Frequency</th></tr>
<tr><td>1</td><td>Patients with an incomplete colonic assessment before colonic resection for colorectal cancer</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	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)		
				2	Personal history of colorectal polyps with malignant potential	1 to 3 years after polypectomy in the presence of high-risk features; otherwise, 3 to 5 years after polypectomy for low-risk polyps
				3	Reassessment of suspected incomplete colonic polypectomy	1 scope within 6 months after polypectomy
				4	Personal history of colorectal malignancy	Every 1 to 3 years starting from 1 year after resection
				5	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: c. 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 d. 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	Claims Indicators (Setting)	Claims Indicators (Clinical Indications/Frequency)
				6 | Patients with a history of rectal cancer who achieved a complete clinical response following neoadjuvant chemotherapy and radiotherapy, and were subsequently managed with a "watch-and-wait" approach | 1 scope every 3 to 6 monthly for the first 2 years, followed by 6 monthly for the next 3 years Same-sitting upper GI endoscopy and colonoscopy/sigmoidoscopy 1. Cancer of unknown origin 2. Investigation for unexplained anaemia 3. Indications fulfilling both upper and lower GI endoscopy

Endoscopic Retrograde Cholangiopancreatography (ERCP) & Endoscopic Ultrasound (EUS) Claims Rules

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications)
SF710B	**3C**	ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (ERCP) WITH SPHINCTEROTOMY /REMOVAL OF STONE/INSERTION OF BILIARY STENT	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** 1. Biliary obstruction e.g. choledocholithiasis (facilitating stone removal), biliary strictures 2. Pancreatic disorders e.g. pancreatic duct leak, pancreatic duct strictures or stones 3. Acute cholangitis 4. Sphincter of Oddi dysfunction 5. Ampullary adenoma 6. To facilitate treatment for post-surgical biliary complications (e.g., biliary stricture, bile leak)

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications)
SF711B	**3A**	BILE DUCT, ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (ERCP)	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** 1. Biliary obstruction a. Choledocholithiasis b. Biliary strictures c. Primary sclerosing cholangitis d. Cancer 2. Pancreatic disorders e.g. pancreatic duct leak, pancreatic duct strictures or stones 3. Acute cholangitis 4. Sphincter of Oddi dysfunction 5. Post-surgical biliary complications (e.g., biliary stricture, bile leak) 6. Biliary/pancreatic stent removal after a cholangiogram/pancreatogram

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications)
SF712B	**3C**	BILE DUCT/ GALL BLADDER, ENDOSCOPY, ENDOSCOPIC SPHINCTEROTOMY +/- EXTRACTION OF STONE	**Inpatient/ day surgery**	**This procedure may be claimed according to the rules below:** 1. Biliary obstruction e.g. choledocholithiasis (facilitating stone removal), biliary strictures 2. Pancreatic disorders e.g. pancreatic duct leak, pancreatic duct strictures or stones 3. Acute cholangitis 4. Sphincter of Oddi dysfunction 5. Ampullary adenoma 6. To facilitate treatment for post-surgical biliary complications (e.g., biliary stricture, bile leak)

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications)
SF717B	**3A**	BOWELS, ENDOSCOPIC ULTRASOUND WITH FINE NEEDLE ASPIRATION	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Admission for acute symptoms 2. Management of acute abdominal pain 3. Septic or at high risk of developing sepsis 4. Requiring post-procedure monitoring or further treatment (higher risk if complex procedures were performed) 5. 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:** This is primarily a procedure for tissue acquisition such as: 1. Pancreaticobiliary disorders: a. Cancer b. Biliary strictures c. Pancreatic abnormalities (mass, chronic pancreatitis, duct dilatation, cyst) d. Gallbladder abnormalities (mass) e. Unexplained biliary duct dilatation 2. Gastrointestinal tract lesions: a. Subepithelial lesions b. Gastrointestinal wall thickening 3. Cancer staging and management 4. Lymph node assessment 5. Abnormal imaging needing tissue diagnosis 6. Therapeutic procedures: a. Drainage b. Fine-needle injection therapies

TOSP Code	Table Code	TOSP Description	Claims Indicators (Setting)	Claims Indicators (Clinical Indications)
SF718B	**2C**	BOWELS, ENDOSCOPIC ULTRASOUND WITHOUT FINE NEEDLE ASPIRATION	**Day surgery** Claims can be made for the **inpatient** setting provided they fulfil one of the following conditions (including but not limited to): 1. Admission for acute symptoms 2. Management of acute abdominal pain 3. Septic or at high risk of developing sepsis 4. Requiring post-procedure monitoring or further treatment (higher risk if complex procedures were performed) 5. 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:** 1. Pancreaticobiliary disorders: a. Cancer b. Biliary strictures c. Pancreatic abnormalities (mass, chronic pancreatitis, duct dilatation, cyst) d. Gallbladder abnormalities (mass) e. Unexplained biliary duct dilatation 2. Gastrointestinal tract lesions: a. Subepithelial lesions b. Gastrointestinal wall thickening 3. Cancer staging and management 4. Lymph node assessment 5. Abnormal imaging 6. Suspected choledocholithiasis

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 filing 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.

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

S/N	TOSP Code	Description	Inappropriate Pairings
1	SF700I (2C)	Oesophagus/ Stomach, Upper GI endoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions/ injection of varices/ removal of single polyp	**SF700I should not be coded with the following:** 1. **SF701I (1B)** Intestine/ Stomach, Upper GI endoscopy with/ without biopsy 2. **SF704E (3A)** Oesophagus/ Stomach/ Colon, gastrointestinal endoscopy, ablative treatment (acceptable if ablative procedure is done in colon) 3. **SF705E (3C)** Oesophagus/ Intestine/ Stomach, upper GI endoscopy with endoscopic submucosal dissection 4. **SF808E (3A)** Oesophagus/ Stomach, Gastroscopy with therapy e.g., APC-Fulgarisation of tumour 5. **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 6. **SF807S (3B)** Stomach, tumour of cardia, endoscopic yag laser surgery/ vaporisation

S/N	TOSP Code	Description	Inappropriate Pairings
			Additionally, none of the codes listed above should be coded together.
2	SF702C (2C)	Colon, Colonoscopy, fibreoptic with/ without biopsy	**SF702C (2C) should not be coded with the following:** 1. **SF704C (3A)** Colon, Colonoscopy, fibreoptic with removal of polyp(s) (single or multiple less than 1cm), with/ without haemostasis 2. **SF704E (3A)** Oesophagus/ Stomach/ Colon, gastrointestinal endoscopy, ablative treatment (acceptable if ablative procedure is done in oesophagus/ stomach) 3. **SF705C (3B)** Colon, Colonoscopy, fibreoptic with removal of polyps (Multiple more than 1cm), with/ without haemostasis 4. **SF708C (3C)** Colon, colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm), with/ without haemostasis 5. **SF710C (1B)** Colon, Sigmoid, Sigmoidoscopy (flexible), Fibreoptic with/ without biopsy 6. **SF711C (1C)** Colon, Sigmoid, Sigmoidoscopy with polypectomy with biopsy 7. **SF807C (4A)** Colon, Colonoscopy, with endoscopic submucosal dissection (ESD) of large polyps (>3cm), with/ without haemostasis 8. **SF806R (2C)** Rectum, tumour, laser vaporisation/ endoscopic fulguration Additionally, none of the codes listed above should be coded together.
3	SF711B (3A)	Bile Duct, Endoscopic Retrograde Cholangiopancreatography (ERCP)	**SF711B (3A) should not be coded with the following:** 1. **SF707B (3C)** Bile Duct/ Gall Bladder, Endoscopic Dilation of Biliary Stricture 2. **SF709B (3C)** Bile Duct/ Gall Bladder, Endoscopic Retrograde Cholangiopancreatography (ERCP) with Insertion of Nasobiliary Drain 3. **SF710B (3C)** Endoscopic Retrograde Cholangiopancreatography (ERCP) with Sphincterotomy/ Removal of Stone/ Insertion of Biliary Stent 4. **SF712B (3C)** Bile Duct/ Gall Bladder, Endoscopy, Endoscopic Sphincterotomy +/- Extraction of Stone

S/N	TOSP Code	Description	Inappropriate Pairings
			Additionally, none of the codes listed above should be coded together.
4	SF717B (3A)	Bowels, endoscopic ultrasound with fine needle aspiration	**SF717B (3A) should not be coded with the following:** 1. **SF718B (2C)** Bowels, endoscopic ultrasound without fine needle aspiration 2. **SF716B (3A)** Bowels, endoscopic ultrasound with coeliac axis neurolysis 3. **SF719B (3C)** Bowels, endoscopic ultrasound with pseudocyst drainage 4. **SF720B (3C)** Bowels, endoscopic ultrasound with stent insertion Additionally, none of the codes listed above should be coded together.