Responses to Clinical Feedback on GI HPB CR

S/N	TOSP Code(s)	Feedback	MOH's Reply
All Procedures			
1	All Procedures	a) The proposed frequency limits may not accommodate clinical scenarios where exceeding the stated thresholds could be clinically justified. There are concerns that fixed limitations may not align with the variability of clinical presentation and could potentially impact clinical decision-making, flexibility, and patient care outcomes.	a) Deviations from Claims Rules are allowed if your doctor can provide medical justifications that are acceptable to an independent Panel of experts.
2	All Procedures	a) Consultation and publication of the Claims Rules should be deferred until the current Hepato-pancreato-biliary (HPB) Table of Surgical Procedures (TOSP) review is completed.	a) The GI HPB CR has been structured in two parts. Part 1 encompasses HPB TOSP codes that include codes with minor descriptor modifications/ changes in table rankings, which are the bile duct and pancreas codes. Part 2 will encompass HPB TOSP codes that have undergone comprehensive review, which are liver codes.
Digestive Tract Resection and Related Procedures			
3	**SF808A** – Abdominal Cavity, Various Lesions, Exploratory Laparotomy (3A)	a) The following indication should be added for SF808A: i. Intra-abdominal/ retroperitoneal post-operative or post-procedural haemorrhage.	a) The proposed change has been incorporated into the CR, under the indications for SF808A.
4	**SF703S** – Stomach, Obesity, Sleeve Gastrectomy (5B)	a) BMI thresholds for SF703S should be lowered to 32.5 and 27.5, in line with more updated international guidelines. b) To change "Patients must have attempted…" to "Patients should have attempted…" in the footnote, as surgery for morbidly obese patients can be used as first line treatment. c) The description for SF703S should include metabolic disease.	a) BMI thresholds are based on the HPB-MOH CPG on Obesity published in 2016 which is currently under review. These will be updated upon the release of the new local CPG. b) The proposed change has been incorporated into the CR, under the footnote for SF703S. c) The proposed change is planned for the upcoming TOSP revision in 2026.

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5	**<u>Colon Resection Procedures</u>** **SF701C** – Colon, Anterior Resection (6C) **SF803C** – Colon, Various Lesions, Right/Left Hemicolectomy (5C) **SF703R** – Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) With/ Without PLND (6C)	a) Indication for colon resection procedures should be rephrased to: i. Adenomas not amenable to endoscopic resection – the adenoma does not need to be large; it can be recurrent adenomas or polyps not cured with repeated endoscopic resection	a) The proposed change has been incorporated into the CR, under the indications for colon resection procedures.
6	**SF701C** – Colon, Anterior Resection (6C)	a) The following indication should be added for SF701C: i. Malignancies in adjacent organs where anterior resection is required for surgical clearance in palliative-intent resection b) SF701C should be described as "high anterior resection", to differentiate it from low anterior resection.	a) The proposed change has been incorporated into the CR, under the indications for SF701C**.** b) The comment has been surfaced to the TOSP Committee for review.
7	**SF803C –** Colon, Various Lesions, Right/Left Hemicolectomy (5C)	a) The following indications should be added for SF803C: i. Colonic malignancy either with histology or clinical suspicion ii. Iatrogenic colonic perforation	a) The proposed changes have been incorporated into the CR, under the indications for SF803C.
8	**SF703R –** Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) With/Without PLND (6C)	a) The following indication should be added for SF703R: i. Tumours in the pelvis invading the rectum (e.g. from sacrum, prostate, bladder, uterus, vagina) b) SF703R should be reclassified to Table 7A due to higher complexity. SF703R should have a separate code if pelvic lymph node dissection is performed.	a) The proposed change has been incorporated into the CR, under the indications for SF703R**.** b) The comment has been surfaced to the TOSP Committee for review.

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9	**SF802C –** Colon, Various Lesions, Colostomy (4A)	a) The following indications should be added for SF802C: i. Unresectable rectal or colonic carcinoma (unresectable left sided colonic tumours and sigmoid volvulus in patients who are deemed too frail to undergo sigmoidectomy) ii. Radiation proctitis or radiation colitis iii. Complicated colon or rectal carcinoma with stenosis iv. Iatrogenic colonic perforation	a) The proposed changes have been incorporated into the CR, under the indications for SF802C.
Hepato-pancreato-biliary Procedures			
10	**<u>Cholecystectomy Procedures</u>** **SF801G –** Gallbladder, Various Lesions, Cholecystectomy (Partial/Total) (4A) **SF706G** – Gallbladder (Complicated) Cholecystectomy (Partial/Total) (4C) **SF704G –** Gallbladder, Various Lesions, Cholecystectomy with Intraoperative Cholangiogram (4B)	a) These indications should be moved from SF801G to SF706G: i. Suspected gallbladder malignancy – steps have to be taken to ensure wider resection margins and with no spillage of bile/perforation of gallbladder, making it a complex cholecystectomy. ii. Acute gallbladder pathology – cholecystectomies with this indication are done as an emergency after hours in sick patients sometimes with generalised sepsis. It will also be hard to determine what is 'mild' acute cholecystitis. b) For SF801G, the phrase 'bile duct clearance' should be removed for the indication "common bile duct stones" as sometimes it is done after the cholecystectomy. c) It is not clear what is defined as "simple" for SF801G, or "complicated" for SF706G.	The proposed changes have been incorporated into the CR, under the indications for cholecystectomy procedures.
11	**SF704G –** Gallbladder, Various Lesions, Cholecystectomy with Intraoperative Cholangiogram (4B)	a) For SF704G, the clinical indication for (Intraoperative cholangiogram) should be rephrased to: i. Possibility of biliary obstruction evidenced by clinical, biochemical abnormalities in liver function or radiological suspicion	a) The proposed change has been incorporated into the CR, under the indications for SF704G.

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12	**SF707G –** Gallbladder, Various Lesions, Cholecystectomy, Choledochotomy, Common Bile Duct Exploration with Choledocho-duodenostomy (5C)	a) SF707G should be claimable for indications outside of stones (e.g. retained stents) requiring common bile duct exploration. b) The description for SF707G should include with/without choledochoduodenostomy.	a) The proposed change has been incorporated into the CR, under the indications for SF707G. b) The proposed change is planned for the upcoming TOSP revision in 2026.
13	**<u>Distal Pancreatectomy</u>** **SF708P –** Pancreas, Various Lesions, Distal Pancreatectomy and Splenectomy (5B) **SF712P –** Pancreas, Various Lesions, Spleen-Preserving Distal Pancreatectomy (5C)	a) In distal pancreatectomy, the pain does not need to be "intractable" to warrant surgery, as pain is subjective. Mild pain with associated clinical or risk factors should be an indication for surgery.	a) The proposed change has been incorporated into the CR, under the indications for SF708P and SF712P.
Other General Surgery Procedures			
14	**<u>Hernia Repair Procedures</u>** **SF819A** – Abdominal Wall, Inguinal/ Femoral Hernia, Unilateral Herniorrhaphy (3B) **SF820A** – Abdominal Wall, Inguinal/ Femoral Hernia, Bilateral Herniorrhaphy (4C) **SF823A** – Abdominal Wall, Ventral/ Incisional/ Recurrent Hernia, Repair (4A)	a) Hernia repair procedures should have an additional indication for the relevant hernia found intraoperatively.	a) Hernias found intraoperatively should not be operated on without the prior consent of the patient.
15	**SF819A –** Abdominal Wall, Inguinal/Femoral Hernia, Unilateral Herniorrhaphy (3B)	a) Can SF819A be used to code for an obturator hernia?	a) The TOSP committee has clarified that SF819A can be used to code for an obturator hernia repair. This has been raised to the TOSP Committee to update the descriptor at the next review.

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16	**SF823A –** Abdominal Wall, Ventral/Incisional/ Recurrent Hernia, Repair (4A)	a) Can SF823A be used to code for medically appropriate diastasis recti?	a) The TOSP committee has clarified that SF823A can be used to code for medically appropriate diastasis recti repair. Diastasis recti repair should only be claimed in cases where the patient is symptomatic (discomfort, core instability, lower back pain) when conservative measures have failed, and not for cosmetic reasons. This has been raised to the TOSP Committee to update the descriptor at the next review.
17	**<u>Adhesiolysis</u>** **SF800A –** Abdominal Cavity, Adhesions (Extensive), Lysis as Primary Procedure, Extensive with or Without Bowel Resection Where Time Taken Is More Than 2 Hours (4A) **SF801A** – Abdominal Cavity, Adhesions (Limited), Lysis as Primary Procedure Where Time Taken Is Less Than 2 Hours (3B)	a) Can adhesiolysis be charged if performed separately by a General Surgeon, given that the primary surgeon is a different speciality (e.g. Gynaecology)?	a) The TOSP booklet states that '*for a single episode of surgery/ procedure, if a single TOSP code adequately describes the surgery/ procedure performed, only one TOSP code should be utilised. This is regardless of the number of primary surgeons involved in the surgery/ procedure.*'
Inappropriate pairings There may be clinical situations where multiple codes are clinically warranted, doctors are reminded to duly document the clinical justification, should the case be called for adjudication. An elaboration of inappropriate pairing principles can be found in paragraph 3 – 5, under the section on "Appropriate filing of General Surgery: Gastrointestinal and Hepato-pancreato-biliary TOSP codes".			
18	**SF808A** – Abdominal Cavity, Various Lesions, Exploratory Laparotomy (3A)	a) SF808A should be allowable with another code, as a positive laparoscopy that detects occult metastases may change the surgical plan for the patient and requires separate incisions, equipment, and expertise to perform.	a) SF808A should not be performed with another definitive procedure. The presence of separate incisions is not the criterion for allowing separate charging.

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19	**<u>Colon Resection Procedures</u>** **SF701C** – Colon, Anterior Resection (6C) **SF803C** – Colon, Various Lesions, Right/Left Hemicolectomy (5C) **SF703R** – Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) With/ Without PLND (6C)	Colon resection procedures should be claimable with a) small bowel resections: i. **SF706I** – Intestine, Small Bowel, Various Lesions, Extensive Resection with Anastomoses, With or Without Stoma (4C) ii. **SF707I** – Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, With or Without Stoma (4A) b) colostomy creation procedures: i. **SF704I** – Intestine, Small Bowel, Various Lesions, Enterostomy (4A) ii. **SF802C** – Colon, Various Lesions, Colostomy (4A) iii. **SF809A** – Abdominal Cavity, Various Lesions, Including Colostomy/Enterostomy/ Gastrostomy (4A)	a) Generally, small bowel and colon resections do not warrant separate coding when performed without requiring additional expertise or substantially increasing surgical complexity. Considering this, the inappropriate pairing of SF706I (extensive small bowel resection) with colon resection procedures has been removed. However, such cases may still be called on for adjudication. b) Defunctioning stoma creation during anterior resection should not be separately coded as it requires no additional expertise or significantly increased complexity.
20	**SF701C** – Colon, Anterior Resection (6C) **SF803C** – Colon, Various Lesions, Right/Left Hemicolectomy (5C)	a) SF701C could be claimable with right hemicolectomy (SF803C), as a sigmoid colon tumour invading into the right colon would require both resections. b) Can an extended right hemicolectomy be coded as a Left + Right Hemicolectomy?	In general, any additional colon resection with SF803C should consider if coding with SF712C – Colon, Total Colectomy / Subtotal Colectomy (6A), or any another single appropriate colectomy code is more appropriate, instead of multiple colectomy codes.
21	**SF701C** – Colon, Anterior Resection (6C) **SF703R** – Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) With/ Without PLND (6C)	a) SF701C and SF703R may be claimable with appendectomy procedures: i. **SF723A** – Appendix, Various Lesions/Abscess, Appendicectomy with Drainage (4A) ii. **SF849A** – Appendix, Various Lesions, Appendicectomy without Drainage (3B)	a) The proposed change has been incorporated into the CR under SF701C and SF703R within Table 1 (Rules regarding inappropriate combinations of General Surgery: GI and HPB CR TOSP codes for a single surgical episode). However, such cases may still be called on for adjudication.
22	**SF803C** – Colon, Various Lesions, Right/Left Hemicolectomy (5C)	a) SF803C should not be claimable with appendectomy procedures: i. **SF723A** – Appendix, Various Lesions/Abscess, Appendicectomy with Drainage (4A) ii. **SF849A** – Appendix, Various Lesions, Appendicectomy without Drainage (3B)	a) The proposed change has been incorporated into the CR under SF803C within Table 1 (Rules regarding inappropriate combinations of General Surgery: GI and HPB CR TOSP codes for a single surgical episode). However, such cases may still be called on for adjudication.

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23	**SF802C –** Colon, Various Lesions, Colostomy (4A)	a) SF802C should not be paired with the following procedures: i. SF805R – Rectum, Tumor, Anterior Resection/ Abdomino- Perineal Resection With Salpingo-Oophorectomy And Total Hysterectomy (6C) ii. SF807R – Rectum, Various Lesions, Abdomino-Perineal Pull Through Resection With Colo-Anal Anastomosis (6B) iii. SF845A – Anus, Tumor, Abdomino-Perineal Resection (6B)	a) The proposed change has been incorporated into the CR under SF802C within Table 1 (Rules regarding inappropriate combinations of General Surgery: GI and HPB CR TOSP codes for a single surgical episode).
24	**SF800I –** Intestine, Enterostomy, Closure (3B) **SF802C** – Colon, Various Lesions, Colostomy (4A) **SF704I** – Intestine, Small Bowel, Various Lesions, Enterostomy (4A)	a) If a patient has multiple stomas that require closing, should multiple codes for stoma closure be used? What about the creation of multiple stomas?	a) The TOSP booklet states that *"For a single episode of surgery/procedure, if a single TOSP code adequately describes the surgery/procedure performed, only one TOSP code should be utilised"*. However, in clinical situations where multiple codes are clinically warranted, doctors are reminded to duly document the clinical justification, should the case be called for adjudication.
25	**<u>Cholecystectomy Procedures</u>** **SF801G –** Gallbladder, Various Lesions, Cholecystectomy (Partial/Total) (4A) **SF706G** – Gallbladder (Complicated) Cholecystectomy (Partial/Total) (4C)	a) Cholecystectomy procedures may be allowable with liver resection codes: i. **SF809L** – Liver, Trauma/Tumor, Extended Lobectomy (5 Segments/More) (7C) ii. **SF812L** – Liver, Various Lesions, Lobectomy (3 - 4 Segments) (6B) iii. **SF813L** – Liver, Various Lesions, Partial Lobectomy/Segmental Resection (5C) iv. **SF815L** – Liver, Various Lesions, Wedge/Local Excision (4C)	a) These pairings will be reviewed as part of deliberations on liver resection codes, as part of the development of Part 2 of the GI HPB CR. Until then, cholecystectomy codes should not be paired with liver resection codes, as stated within the Claims Rules.
26	**<u>Pancreatectomy procedures</u>** **SF708P** – Pancreas, Various Lesions, Distal Pancreatectomy	Pancreatectomy procedures should be allowable with a) colon resection procedures: i. **SF701C** – Colon, Anterior Resection (6C) ii. **SF803C** – Colon, Various Lesions, Right/Left Hemicolectomy (5C)	a) Pancreatectomy procedures may be claimed with colon resection procedures, if they do not contravene the principles found within the CR and the TOSP booklet.

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	and Splenectomy (5B) **SF712P** – Pancreas, Various Lesions, Spleen-Preserving Distal Pancreatectomy (5C) **SF709P –** Pancreas, Various Lesions, Subtotal Pancreatectomy (Extending to the Neck) and Splenectomy (5C) **SF809P –** Pancreas, Various Lesions, Whipple Operation/Total Pancreatectomy (7C)	iii. **SF703R** – Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) With/Without PLND (6C)	