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MediShield Life Claims Rules for General Surgery: Gastrointestinal and Hepato-Pancreato-Biliary Procedures

CLAIMS MANAGEMENT OFFICE

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MediShield Life Claims Rules for General Surgery: Gastrointestinal and Hepato-Pancreato-Biliary Procedures

Contents

Definitions

Terminology	Definition
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 (see Section 4.6 of the Manual on MediSave Scheme), and who is admitted and discharged within 12 hours. *NB: For the purposes of this document, day surgery under 'setting' will include surgical procedures performed in medical facilities such as Outpatient clinic, 'Short Stay Unit', and Ambulatory Surgical Centres.*
Surgical/Procedural Episode	Refers to the entire suite of services provided during the time the patient arrives to the operating theatre complex until the patient leaves. If the patient requires anaesthesia, the continuous period under General Anaesthesia/Sedation is also defined under the same surgical episode.

General Comments

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.

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-effectiveness guidelines; and

(iii) verified against available past claims data to ensure that they cover the vast majority of claims that are medically appropriate.

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

The CR are not exhaustive. Deviation from CR is allowed if clinically justified. The treating doctor should inform his patient of the deviation, perform relevant documentation, and be prepared to provide justification, if queried by payors or regulators.

Procedures usually done in a day surgery setting have a non-exhaustive list of conditions where claims for inpatient admission 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 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 include those defined as 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.

B. How to use the Claims Rules

Each set of CR are based upon a subset of specialty-specific Table of Surgical Procedures (TOSP) codes. These are priority areas identified as procedures with high volume of claims 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 Claims Rules where available and Singapore Medical Council (SMC)'s Ethical Code and Ethical Guidelines (ECEG).

The TOSP codes in this CR are arranged by anatomical parts (e.g. colon, gallbladder, anus). 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).

These rules work in tandem with the Guidelines on 2M claims as well as the general TOSP coding principles in the TOSP booklet to guide appropriate coding practices.

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

Message from the General Surgery: Gastrointestinal and Hepato-Pancreato-Biliary Workgroup

MediShield Life is a basic, universal national health insurance scheme funded through premiums paid by Singaporeans and Permanent Residents. With complexities in surgical procedures, it is necessary to define appropriate claims under MediShield Life Claims Rules to ensure accuracy of claims made and safeguard against unnecessary premium increases. Claims Rules are not meant to be practice guidelines but are guided by clinical practice. They are developed by the workgroup appointed by the Ministry of Health, comprising specialists from both public and private sectors in the areas of General Surgery with sub-specialty interests in colorectal, upper gastrointestinal and hepatopancreatobiliary surgery to ensure appropriate and fair representation. These claim rules have also gone through external consultation with the Academy of Medicine, professional societies, hospitals, Integrated Shield Plan Insurers and the medical community at large.

The workgroup relies on evidence-based literature, prevailing clinical practice, and cost-effective guidelines to formulate the Claims Rules. Whilst the Claims Rules are not meant to be exhaustive, the workgroup has sought to cover the common surgical procedures in GI and HPB practice, taking into consideration the current Table of Surgical Procedures (TOSP) codes and their inherent definitions. The Claims Rules are meant to be a guide for the practitioner and covers the majority of clinical scenarios, with the understanding that outlier situations may occur in clinical practice that fall outside these rules. When claims fall outside of these stated guidelines, claims are still possible after review and if deemed medically appropriate by the MediShield Life Council's appointed panel of relevant specialists.

Prof London Lucien Ooi Peng Jin

Chairman

On behalf of the General Surgery: Gastrointestinal and Hepato-Pancreato-Biliary Workgroup, comprising:

(In Alphabetical Order)

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Digestive Tract Resection and Related Claims Rules

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF808A	**3A**	ABDOMINAL CAVITY, VARIOUS LESIONS, EXPLORATORY LAPAROTOMY[1]	**Inpatient / Day Surgery**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Acute-onset abdominal pain and clinical findings suggestive of intra-abdominal pathology necessitating emergency surgery, such as but not limited to: a. Presenting with clinical features of peritonitis, especially with pneumoperitoneum b. Intestinal obstruction of uncertain cause, where incarcerated inguinal hernia has been ruled out c. Patients with intra-abdominal collections, determined through imaging (e.g. ultrasonography, CT scan) and not manageable through percutaneous means d. Intraperitoneal sepsis due to perforated gastrointestinal tract 2. Abdominal trauma with hemodynamic instability, hemoperitoneum or in decompensated patients 3. Staging of malignancy (e.g. ovarian, Hodgkin disease) 4. Obscure gastrointestinal bleeding where imaging modalities are insufficient to adequately determine the source of bleeding 5. Unusual presentation where other modalities of exploration have yielded uncertain results. 6. Intra-abdominal/retroperitoneal haemorrhage post-procedure **SF808A is a standalone code and should not be used with other codes for any intra-abdominal operation.**

[1] SF808A can also be used for diagnostic/staging laparoscopy.

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF810A	**4A**	ABDOMINAL CAVITY, VARIOUS LESIONS, NOT CLASSIFIED ELSEWHERE	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Instances where no other TOSP code appropriately describes the procedure performed and; 2. Procedure must be limited to the abdominal cavity **SF810A should only be claimed as a standalone code in a single surgical episode, without any other intra-abdominal operation.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF703S	**5B**	STOMACH, OBESITY, SLEEVE GASTRECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Patients with a BMI greater than 37.5kg/m^2 2. Patients with a BMI greater than 32.5kg/m^2 with a concomitant medical condition related to obesity such as: a. Type 2 Diabetes b. Obstructive Sleep Apnea c. Hypertension 3. Children (<18 y/o) with a BMI >120% of the 95th percentile *[NB: Indications 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.]* **Patients should have attempted and failed dietary and lifestyle intervention alone and deemed to have low probability of success with non-surgical weight-loss measures.** **Frequency: 1 claim per patient** **Frequency limits may be exceeded when medically indicated, provided the treating physician documents the clinical justification, informs the patient of the deviation, and maintains supporting documentation that may be required for payor or regulatory queries.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF707I	**4A**	INTESTINE, SMALL BOWEL, VARIOUS LESIONS, SIMPLE RESECTION WITH ANASTOMOSES, WITH OR WITHOUT STOMA	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Bleeding source in small bowel from causes including but not limited to a. Small bowel ulceration b. Severe Crohn's disease c. Radiation enteritis 2. Bowel obstruction of small bowel from causes including but not limited to a. Suspected or confirmed malignancy b. Occlusive benign masses c. Post inflammatory strictures 3. Ischaemic bowel from causes including but not limited to a. Adhesions with vascular compromise b. Midgut volvulus c. Thromboembolic causes d. Necrotizing enterocolitis 4. Bowel perforation from causes including but not limited to a. Irreparable trauma b. Non-traumatic reasons, coupled with concomitant factors to prefer resection over repair (e.g. malignancy, inflammatory bowel disease) 5. Congenital diseases of the small bowel including but not limited to a. Bowel Atresia b. Enteric Duplication Cyst c. Meckel's Diverticulum 6. Other relevant causes requiring intestinal resection **In instances of more than one intestinal resection in the same surgery, instead of multiple instances of SF707I, SF706I (Intestine, Small Bowel, Various Lesions, Extensive Resection with Anastomoses, with or without Stoma) should be coded instead.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF701C	**6C**	COLON, ANTERIOR RESECTION	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Sigmoid or rectal malignancy either with a. histologic confirmation before or after surgery, or b. clinical suspicion based on colonoscopic or CT findings. 2. Malignancies in adjacent organs where an anterior resection is required to obtain R0 resection margin 3. Adenomas not amendable for endoscopic resection 4. Acute Diverticulitis, either with a. Severe inflammation (Hinchey Classification stage III or IV or equivalent), or b. Recurrent, or c. Complicated, characterised by perforation, obstruction, abscess, fistula, feculent or purulent peritonitis, or d. After failure of non-operative treatment (e.g. gut rest, antibiotics) 5. After successful non-operative treatment of complicated diverticulitis 6. Diverticulosis with massive lower GI bleeding 7. Trauma leading to bowel perforation of rectum 8. Colonic strictures that cannot be endoscopically surveyed 9. Gastrointestinal haemorrhage that has been localised to the specific part of the colon **Frequency: 1 claim per patient** **Frequency limits may be exceeded when medically indicated, provided the treating physician documents the clinical justification, informs the patient of the deviation, and maintains supporting documentation that may be required for payor or regulatory queries.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF802C	**4A**	COLON, VARIOUS LESIONS, COLOSTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Unresectable or obstructing malignancy in patients unsuitable for primary resection or bypass 2. Complex fistulous disease (perianal, rectovaginal, rectourethral, or rectovesical) not amenable to primary repair 3. Severe inflammatory bowel disease requiring faecal diversion (including Crohn's perianal sepsis, fulminant colitis) 4. Radiation-induced proctocolitis refractory to conservative management 5. Colorectal trauma with sphincter injury or extensive tissue loss 6. Perineal necrotising fasciitis 7. Iatrogenic colonic perforation not suitable for primary repair 8. Severe faecal incontinence not amenable to conservative or reconstructive therapy 9. Anastomotic leak requiring faecal diversion 10. Hirschsprung's Disease, anorectal malformation and other congenital intestinal anomalies requiring diversion **Frequency: 1 claim per patient** **Frequency limits may be exceeded when medically indicated (e.g. revision of colostomy), provided the treating physician documents the clinical justification, informs the patient of the deviation, and maintains supporting documentation that may be required for payor or regulatory queries.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF803C	**5C**	COLON, VARIOUS LESIONS, RIGHT/LEFT HEMICOLECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Appendiceal or colonic malignancy either with a. histologic confirmation before or after surgery, or b. clinical suspicion based on colonoscopic or CT findings. 2. Adenomas not amendable for endoscopic resection 3. Acute diverticulitis, either with a. Severe inflammation (Hinchey Classification stage III or IV or equivalent), or b. Recurrent episodes, or c. Complicated (characterised by perforation, obstruction, abscess, fistula, feculent or purulent peritonitis), or d. After failure of non-operative management (e.g. gut rest, antibiotics) 4. After successful non-operative treatment of complicated diverticulitis 5. Isolated left/right side diverticulosis with massive lower GI bleeding 6. Severe cases of Crohn's disease, either a. where previous conservative treatment has failed (inadequate response, complications or non-adherence to medical therapy etc.), or b. With acute small bowel obstruction (for right hemicolectomy only), or c. In refractory Crohn colitis 7. Trauma leading to bowel perforation 8. Colonic strictures that cannot be endoscopically surveyed 9. Colitis with perforation 10. Strangulated hernia requiring resection 11. Paediatric intestinal conditions including but not limited to: a. Necrotizing enterocolitis b. Colonic atresia 12. Severe appendicitis requiring right hemicolectomy 13. Extra-colonic malignancy involving the colon, where segmental colonic resection is clinically indicated

				Frequency: 2 claims per patient **1 claim for left hemicolectomy, 1 claim for right hemicolectomy** **Frequency limits may be exceeded when medically indicated, provided the treating physician documents the clinical justification, informs the patient of the deviation, and maintains supporting documentation that may be required for payor or regulatory queries.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF800I	**3B**	INTESTINE, ENTEROSTOMY, CLOSURE	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. In instances where the enterostomy is no longer needed **Frequency: 1 claim per patient per year** **Frequency limits may be exceeded when medically indicated, provided the treating physician documents the clinical justification, informs the patient of the deviation, and maintains supporting documentation that may be required for payor or regulatory queries.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF703R	**6C**	RECTUM, ULTRA-LOW ANTERIOR RESECTION (TOTAL MESORECTAL EXCISION) WITH/WITHOUT PLND	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Resectable tumours in the middle and lower rectum 2. Resection of tumours in the pelvis invading the rectum (e.g. sacrum, prostate, bladder, uterus, vagina) 3. Adenomas not amendable for endoscopic resection **Frequency: 1 claim per patient**

HPB Claims Rules

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF801G	**4A**	GALLBLADDER, VARIOUS LESIONS, CHOLECYSTECTOMY (PARTIAL/TOTAL)	**Inpatient/Day surgery** Cholecystectomy can be offered as a day surgery in elective instances of cholecystectomy.	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Symptomatic gallstones, verified by imaging with symptoms attributable to a gallbladder cause 2. Gallbladder involvement by other malignancies 3. Gallbladder polyps with clinical suspicion (size > 10mm, interval size increase, or enhancement on imaging) 4. Common bile duct stones 5. Gallstone pancreatitis 6. Biliary dyskinesia **Frequency: 1 claim per patient across all cholecystectomy codes** **If a completion cholecystectomy is needed after previous partial or subtotal cholecystectomy, SF706G: Gallbladder (Complicated) Cholecystectomy (Partial/Total) should be claimed instead.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF704G	**4B**	GALLBLADDER, VARIOUS LESIONS, CHOLECYSTECTOMY WITH INTRAOPERATIVE CHOLANGIOGRAM	**Inpatient/Day Surgery** Cholecystectomy can be offered as a day surgery in elective instances of cholecystectomy.	**This procedure may be claimed according to the rules below: A patient should be indicated for both cholecystectomy and intraoperative cholangiogram, based on the below criteria.** **Clinical Indications (Cholecystectomy):** 1. Symptomatic gallstones, verified by imaging with symptoms attributable to a gallbladder cause 2. Gallbladder involvement by other malignancies 3. Gallbladder polyps with clinical suspicion (size > 10mm, interval size increase, or enhancement on imaging) 4. Common bile duct stones 5. Gallstone pancreatitis 6. Biliary dyskinesia **Clinical indications (Intraoperative cholangiogram):** 1. To delineate anatomy and detect incidental abnormalities 2. Possibility of biliary obstruction evidenced by clinical, biochemical abnormalities in liver function or radiological suspicion 3. History of gallstone pancreatitis 4. Common bile duct diameter above expected norm 5. Suspected bile duct injury **Frequency: 1 claim per patient across all cholecystectomy codes** **If a completion cholecystectomy is needed after previous partial or subtotal cholecystectomy, SF706G: Gallbladder (Complicated) Cholecystectomy (Partial/Total) should be claimed instead.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF706G	**4C**	GALLBLADDER (COMPLICATED) CHOLECYSTECTOMY (PARTIAL/TOTAL)	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Acute gallbladder pathology – acute cholecystitis, acalculous cholecystitis, gangrenous cholecystitis, emphysematous cholecystitis, empyema gallbladder 2. Suspected gallbladder malignancy 3. Contracted, fibrotic gallbladder 4. Dense adhesions from any cause including previous surgery 5. Unclear anatomy 6. Mirizzi syndrome 7. Completion cholecystectomy after previous partial or subtotal cholecystectomy **Frequency: 2 claims per patient across all cholecystectomy codes** **Second claim only allowed for completion cholecystectomy after previous partial or subtotal cholecystectomy.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF707G	**5C**	GALLBLADDER, VARIOUS LESIONS, CHOLECYSTECTOMY, CHOLEDOCHOTOMY, COMMON BILE DUCT EXPLORATION WITH CHOLEDOCHO-DUODENOSTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Blockages (e.g. common bile duct stones, retained stents) diagnosed by preoperative imaging 2. Blockages (e.g. common bile duct stones, retained stents) suspected intraoperatively from intraoperative cholangiogram **Frequency: 1 claim per patient** **If a completion cholecystectomy is needed after previous partial or subtotal cholecystectomy, SF706G: Gallbladder (Complicated) Cholecystectomy (Partial/Total) should be claimed instead.**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF708P	**5B**	PANCREAS, VARIOUS LESIONS, DISTAL PANCREATECTOMY AND SPLENECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Benign or malignant tumours involving the body or tail of the pancreas located to the left of the superior mesenteric vein 2. Painful chronic pancreatitis confined to the body or tail 3. Pseudocyst involving the tail of the pancreas not suitable for other procedures 4. Trauma to the distal pancreas 5. Disruption of pancreatic duct in body/tail of pancreas 6. Stricture of pancreatic duct in body/tail 7. Concurrent resection with adjacent tumour involvement 8. Congenital hyperinsulinaemic hypoglycaemia (focal) in infants **Frequency: 1 claim per patient across Distal Pancreatectomy Codes (i.e. SF708P, SF712P*)** ***SF712P – Pancreas, Various Lesions, MIS/Open Spleen-Preserving Distal Pancreatectomy**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF712P	**5C**	PANCREAS, VARIOUS LESIONS, MIS/OPEN SPLEEN-PRESERVING DISTAL PANCREATECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Benign or malignant tumours involving the body or tail of the pancreas located to the left of the superior mesenteric vein 2. Painful chronic pancreatitis confined to the body or tail 3. Pseudocyst involving the tail of the pancreas not suitable for other procedures 4. Trauma to the distal pancreas 5. Disruption of pancreatic duct in body/tail of pancreas 6. Stricture of pancreatic duct in body/tail 7. Concurrent resection with adjacent tumour involvement 8. Congenital hyperinsulinaemic hypoglycaemia (focal) in infants **Frequency: 1 claim per patient across Distal Pancreatectomy Codes (i.e. SF708P*, SF712P)** **SF708P – Pancreas, Various Lesions, Distal Pancreatectomy and Splenectomy**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF709P	**5C**	PANCREAS, VARIOUS LESIONS, MIS/OPEN SUBTOTAL PANCREATECTOMY (EXTENDING TO THE NECK) AND SPLENECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Benign or malignant tumours in the neck +/- extension to the body/tail of the pancreas. 2. Chronic pancreatitis in the neck of the pancreas +/- extension to the body/tail with intractable pain. 3. Pseudocysts involving the neck of the pancreas +/- extension to the body/tail that are not suitable for other procedures. 4. Trauma involving the neck +/- extension to the body/tail of the pancreas. 5. Disruptions of the pancreatic duct in the neck of the pancreas +/- extension to the body/tail. 6. Strictures of the pancreatic duct in the neck of the pancreas +/- extension to the body/tail. 7. Concurrent resection with adjacent tumour involvement 8. Completion after previous Whipple procedure for new lesion in the body/tail of pancreas (new primary or recurrent disease) 9. Completion after previous Whipple procedure for remnant pancreatic necrosis or disrupted pancreatojejunostomy not amenable to repair 10. Congenital hyperinsulinaemic hypoglycaemia (diffuse) **Frequency: 1 claim per patient**

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF809P	**7C**	PANCREAS, VARIOUS LESIONS, WHIPPLE OPERATION/TOTAL PANCREATECTOMY	**Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Suspected/confirmed tumours of the pancreatic head +/- extension to body 2. Suspected/confirmed tumours of the pancreatic head +/- concomitant tumours in the body/tail 3. Suspected/confirmed tumours of the duodenum 4. Suspected/confirmed tumours of the distal bile duct 5. Suspected/confirmed tumours of the Ampulla of Vater 6. Adjacent tumours requiring the removal of the pancreaticoduodenal complex 7. Trauma to head of pancreas or duodenum 8. Chronic pancreatitis **Frequency: 1 claim per patient**

Other General Surgery Procedures

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF819A	**3B**	ABDOMINAL WALL, INGUINAL/FEMORAL HERNIA, UNILATERAL HERNIORRHAPHY	**Day surgery/Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Presence of a unilateral inguinal or femoral hernia diagnosed through a. clinical history taking and physical examination, or b. imaging

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF820A	**4C**	ABDOMINAL WALL, INGUINAL/FEMORAL HERNIA, BILATERAL HERNIORRHAPHY	**Day surgery/Inpatient**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Presence of a bilateral inguinal or femoral hernia diagnosed through either: a. clinical history taking and physical examination, or b. imaging

TOSP Code	Table Code	TOSP Description	Claim Indicators (Setting)	Claim Indicators (Clinical Indications/Frequency/Modality)
SF823A	**4A**	ABDOMINAL WALL, VENTRAL/INCISIONAL/ RECURRENT HERNIA, REPAIR	**Inpatient/Day surgery**	**This procedure may be claimed according to the rules below:** **Clinical Indications:** 1. Presence of ventral/abdominal, incisional/post-surgical or any other recurrent hernia diagnosed through either a. relevant clinical history taking and physical examinations, or b. imaging **Ventral hernia in the context of this TOSP code is defined as a hernia in the anterior abdominal wall, excluding epigastric/umbilical hernias (which should be coded under SF814A (3A)).** **This code should not be used to code for an abdominoplasty, which should be coded as SA896S.**

Appropriate filing of General Surgery: Gastrointestinal and Hepato-Pancreato-Biliary 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 (paragraph 8 to 10 of **Annex**). Generally, it would be inappropriate to:

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

2 To monitor and govern the TOSP filling and to ensure claims appropriateness, MOH have put together a list of **inappropriate combinations of HPB and GI TOSP codes that should not be claimed in a single surgical episode in Table 1 below.** Please note that the list serves as a reference and may be non-exhaustive. There may be clinical situations where multiple codes are clinically warranted. For such cases, doctors are reminded to duly document the clinical justification, should the case be called for adjudication.

3 For patients undergoing additional steps in a procedure which does not require additional expertise beyond what is required for the original surgery nor substantially increases the complexity of the surgery nor lead to a significantly higher complication rate or poorer surgical outcomes (for example due to anatomy variations or operative complications), an additional TOSP code should not be coded.

4 For example, if a single segment of small intestines was resected en masse with a hemicolectomy due to inadvertent bowel perforation from dense adhesions, the additional small intestines resection should not be subjected to an additional code. This is because the additional surgery does not require additional surgical expertise, additional anaesthetic management and the additional single bowel anastomosis is generally not associated with much higher morbidity and greater degree of surgical complexity. Using similar principles, a defunctioning stoma creation during an anterior resection should not be separately coded as well.

5 If the main surgery and any additional procedures are already adequately covered by another existing TOSP code, then that TOSP code should be applied.

Table 1: <u>Rules regarding inappropriate combinations of General Surgery: GI and HPB CR TOSP codes for a single surgical episode</u>

S/N	TOSP code	Inappropriate Pairings
1	**SF808A (3A)** Abdominal Cavity, Various Lesions, Exploratory Laparotomy	SF808A should not be coded with any other abdominal operation.
2	**SF810A (4A)** Abdominal Cavity, Various Lesions, Not Classified Elsewhere	SF810A should not be coded with any other intra-abdominal procedure.
3	**<u>Intussusception codes</u>** **SF801I (3B)** Intestine, Intussusception, Reduction **SF802I (2A)** Intestine, Intussusception, Reduction by Fluid	Only 1 Intussusception code can be claimed in a single procedure.
4	**SF707I (4A)** Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, with or without Stoma	SF707I should not be coded with the following: i. **SF701C (6C)** Colon, Anterior Resection ii. **SF803C (5C)** Colon, Various Lesions, Right/Left Hemicolectomy iii. **SF703R (6C)** Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) with/without PLND iv. **SF704I (4A)** Intestine, Small Bowel, Various Lesions, Enterostomy v. **SF809A (4A)** Abdominal Cavity, Various Lesions, Including Colostomy/Enterostomy/Gastrostomy vi. **SF706I (4C)** Intestine, Small Bowel, Various Lesions, Extensive Resection With Anastomoses, With Or Without Stoma vii. **SF707I (4A)** Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, with or without Stoma
5	**SF701C (6C)** Colon, Anterior Resection	SF701C should not be coded with the following: i. **An additional code of SF701C** ii. **SF707I (4A)** Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, with or without Stoma iii. Another Anterior Resection code (e.g. **SF703R (6C)** Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) with/without PLND) iv. Another Colectomy code which covers the same territory as Anterior Resection a. SF804C (6A) Colon, Various Lesions, Total Colectomy with Ileorectal Anastomosis/Ileostomy

S/N	TOSP code	Inappropriate Pairings
		b. SF712C (6A) Colon, Total Colectomy / Subtotal Colectomy c. SF805C (6B) Colon, Various Lesions, Total Procto-Colectomy and Ileostomy d. SF806C (5C) Colon, Various Lesions, Transverse/Sigmoid Colectomy (MIS/Open) v. Another Colectomy code in which the addition to an Anterior Resection already has another existing TOSP code which adequately describes the procedure a. SF712C (6A) Colon, Total Colectomy / Subtotal Colectomy - If Anterior Resection is done with Total / Subtotal Colectomy, a Total Proctocolectomy code should be claimed (SF805C (6B) Colon, Various Lesions, Total Procto-Colectomy and Ileostomy vi. A Colostomy code a. SF800C (4A) Colon, Colostomy, Closure without Resection of Bowel b. SF802C (4A) Colon, Various Lesions, Colostomy c. SF809A (4A) Abdominal Cavity, Various Lesions, Including Colostomy/ Enterostomy/ Gastrostomy
6	**SF803C (5C)** Colon, Various Lesions, Right/Left Hemicolectomy	SF803C should not be coded with the following: i. **An additional code of SF803C** ii. **SF806C (5C)** Colon, Various Lesions, Transverse/Sigmoid Colectomy iii. **SF723A (4A)** Appendix, Various Lesions/Abscess, Appendicectomy with Drainage iv. **SF849A (3B)** Appendix, Various Lesions, Appendicectomy without Drainage v. **SF707I (4A)** Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, with or without Stoma vi. Another Colectomy code which covers the same territory as Right/Left Hemicolectomy a. SF848A (5C) Appendix, Tumor, Right Hemicolectomy with/without Adhesiolysis (Open or Lap) (SF803C can be claimed if a left hemicolectomy is done) b. SF712C (6A) Colon, Total Colectomy/Subtotal Colectomy c. SF713C (6C) Colon, Total Proctocolectomy and Ileo-Anal Pouch Reconstruction d. SF804C (6A) Colon, Various Lesions, Total Colectomy with Ileorectal Anastomosis/Ileostomy e. SF805C (6B) Colon, Various Lesions, Total Procto-Colectomy and Ileostomy) vii. A Colostomy code a. SF800C (4A) Colon, Colostomy, Closure without Resection of Bowel b. SF802C (4A) Colon, Various Lesions, Colostomy c. SF809A (4A) Abdominal Cavity, Various Lesions, Including Colostomy/ Enterostomy/ Gastrostomy

S/N	TOSP code	Inappropriate Pairings
7	**SF703R (6C)** Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) with/without PLND	SF703R should not be coded with the following: i. **An additional code of SF703R** ii. **SE707L (5A)** Lymph Node (Pelvic) Dissection, Unilateral/Bilateral iii. **SF704I (4A)** Intestine, Small Bowel, Various Lesions, Enterostomy iv. **SF707I (4A)** Intestine, Small Bowel, Various Lesions, Simple Resection with Anastomoses, with or without Stoma v. Another Anterior Resection code eg **SF701C (6C)** Colon, Anterior Resection (OpenMIS) vi. Another Colectomy code which covers the same territory as Ultra-Low Anterior Resection a. SF804C (6A) Colon, Various Lesions, Total Colectomy with Ileorectal Anastomosis/Ileostomy b. SF712C (6A) Colon, Total Colectomy / Subtotal Colectomy c. SF805C (6B) Colon, Various Lesions, Total Procto-Colectomy and Ileostomy d. SF806C (5C) Colon, Various Lesions, Transverse/Sigmoid Colectomy (MIS/Open) – For this code, the overlapping bowel segment with Anterior Resection is just the Sigmoid vii. Another Colectomy code in which the addition to an Ultra-Low Anterior Resection already has another existing TOSP code which adequately describes the procedure a. SF712C (6A) Colon, Total Colectomy / Subtotal Colectomy – If Ultra-Low Anterior Resection is done with Total / Subtotal Colectomy, a Total Proctocolectomy code should be claimed (SF805C (6B) Colon, Various Lesions, Total Procto-Colectomy and Ileostomy) viii. A Colostomy code a. SF800C (4A) Colon, Colostomy, Closure without Resection of Bowel b. SF802C (4A) Colon, Various Lesions, Colostomy c. SF809A (4A) Abdominal Cavity, Various Lesions, Including Colostomy/ Enterostomy/ Gastrostomy
8	**SF802C (4A)** Colon, Various Lesions, Colostomy	SF802C should not be coded with the following: i. **SF701C (6C)** Colon, Anterior Resection ii. **SF803C (5C)** Colon, Various Lesions, Right/Left Hemicolectomy iii. **SF703R (6C)** Rectum, Ultra-Low Anterior Resection (Total Mesorectal Excision) with/without PLND iv. **SF805R (6C)** Rectum, Tumor, Anterior Resection/ Abdomino- Perineal Resection With Salpingo-Oophorectomy And Total Hysterectomy v. **SF807R (6B)** Rectum, Various Lesions, Abdomino-Perineal Pull Through Resection With Colo-Anal Anastomosis vi. **SF845A (6B)** Anus, Tumor, Abdomino-Perineal Resection

S/N	TOSP code	Inappropriate Pairings
9	**<u>Cholecystectomy codes</u>** **SF801G (4A)** Gallbladder, Various Lesions, Cholecystectomy (Partial/total) **SF706G (4C)** Gallbladder (Complicated) Cholecystectomy (Partial/total) **SF701G (6C)** Gallbladder, Tumour, Radical Cholecystectomy with Segment 4b and 5 Liver Resection and Radical Lymphadenectomy **SF702G (7A)** Gallbladder, Tumour, Radical Cholecystectomy with Segment 4b and 5 Liver Resection and Radical Lymphadenectomy and Choledochectomy with Hepatico-Enteric Anastomosis **SF703G (6A)** Gallbladder, Various Lesions, Cholecystectomy and Repair of Cholecysto-Enteric/ Cholecystocholedochal Fistula **SF704G (4B)** Gallbladder, Various Lesions, Cholecystectomy with Intraoperative Cholangiogram **SF705G (5A)** Gallbladder, Various Lesions, Cholecystectomy and Transcystic Common Bile Duct Exploration **SF707G (5C)** Gallbladder, Various Lesions, Cholecystectomy, Choledochotomy, Common Bile Duct Exploration with Choledocho-Duodenostomy **SF802G (5C)** Gallbladder, Various Lesions, Cholecystectomy and Choledochojejunostomy/ Duodenostomy/Gastrostomy	Cholecystectomy codes should not be coded with the following: i. **SF809P (7C)** Pancreas, Various Lesions, Whipple Operation/total Pancreatectomy ii. **SF809L (7C)** Liver, Trauma/Tumour, Extended Lobectomy (5 Segments/More) iii. **SF812L (6B)** Liver, Various Lesions, Lobectomy (3 - 4 Segments) iv. **Other Cholecystectomy codes**

S/N	TOSP code	Inappropriate Pairings
10	**<u>Pancreas Enucleation Codes</u>** **SF705P (4C)** Pancreas, Various Lesions, Enucleation of Lesions (1 to 2) **SF706P (5A)** Pancreas, Various Lesions, Enucleation of Lesions (3 or More)	Only 1 Pancreas Enucleation code can be claimed in a single procedure.
11	**<u>Distal Pancreatectomy Codes</u>** **SF708P (5B)** Pancreas, Various Lesions, Distal Pancreatectomy and Splenectomy **SF712P (5C)** Pancreas, Various Lesions, Spleen-Preserving Distal Pancreatectomy	SF708P should not be coded with the following: i. **SE803S (4A)** Spleen, Various Non-Traumatic Lesions, Splenectomy ii. **SF702P (7C)** Pancreas, Transplant (Recipient) iii. **Another Distal Pancreatectomy code**
12	**SF809P (7C)** Pancreas, Various Lesions, Whipple Operation/total Pancreatectomy	SF809P should not be coded with the following: i. **SE807L (4B)** Lymph Node (Retroperitoneal), Various Lesions, Limited Excision ii. **SF808S (4A)** Stomach, Tumour/Ulcer, Gastrojejunostomy iii. **SF804B (5C)** Bile Duct, Various Lesions. Hepaticojejunostomy up to but not including the Confluence of the Hepatic Ducts iv. **Any cholecystectomy codes (see S/N 9)**
13	**SF823A (4A)** Abdominal Wall, Ventral/Incisional/Recurrent Hernia, Repair	SF823A should not be coded with the following: i. **SF814A (3A)** Abdominal Wall, Epigastric/Umbilical Hernia, Repair unless the patient has an umbilical hernia and an incisional hernia of an abdominal scar that is not in the midline (e.g. open cholecystectomy incision, Pffanstiel incision)