Responses to Clinical Feedback on GI Endoscopy CR (Review)

S/N	TOSP Code(s)	Feedback	MOH's Reply
Colonoscopy procedures			
1	<u>All colonoscopy and sigmoidoscopy procedures</u> **SF702C** – Colon, colonoscopy, fibreoptic with/without biopsy (2C) **SF704C** – Colon, colonoscopy, fibreoptic with removal of polyp (s) (single or multiple less than 1cm), with/without haemostasis (3A) **SF705C** – Colon, colonoscopy, fibreoptic with removal of polyps (multiple more than 1cm), with/without haemostasis (3B) **SF708C** – Colon, colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm), with/without haemostasis (3C) **SF710C** – Colon, sigmoid, sigmoidoscopy (flexible), fibreoptic with/without biopsy (1B) **SF711C** – Colon, sigmoid, sigmoidoscopy with polypectomy with biopsy (1C) **SF807C** – Colon, colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm), with/without haemostasis (4A)	a) While I understand the need to be prudent, there is no medical basis of 2 weeks of medical therapy. Stenosing colon cancer can also improve with laxatives but does not address the underlying issue. Patients of the appropriate age group with symptoms should be considered for endoscopic evaluation. b) To rephrase the indication "*Abdominal bloating or pain for more than 2 weeks that does not respond to medical therapy for at least 2 weeks with no colonoscopy in the last 3 years*" to "*Abdominal bloating or pain for more than 2 weeks with no colonoscopy in the last 3 years*".	The CR for **SF702C, SF704C, SF705C, SF708C, SF710C, SF711C** and **SF807C** have been amended to reflect the proposed change as follows: "*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 for the past 3 years, unless specifically medically justified and documented*".
		a) For subsequent colonoscopies, second opinion may be considered even if a biopsy was taken, to assess the suitability for endoscopic resection, as large polyps can be heterogenous and the initial biopsies may not be representative. b) To rephrase the indication "*For a second opinion of the lesion where a biopsy was not taken*" to "*For a second opinion of a lesion for consideration of endoscopic resection*".	The CR for **SF702C, SF704C, SF705C, SF708C, SF710C, SF711C** and **SF807C** have been amended to reflect the proposed change as follows: "*For a second opinion on suitability of endoscopic resection or biopsy/re-biopsy*".
		a) Under Claim Indicators for inpatient setting, to include paediatric patients for inpatient bowel preparation	The CR for **SF702C, SF704C, SF705C, SF708C, SF710C** and **SF711C** have been amended to reflect the proposed change.
		a) As many paediatric patients undergoing endoscopy for foreign body retrieval may not present with symptoms, to change "*acute abdominal symptoms*" to "*acute abdominal conditions*".	The CR for **SF702C, SF704C, SF705C, SF708C, SF710C** and **SF711C** have been amended to reflect the proposed change.
		a) For subsequent colonoscopies, the paediatric inflammatory bowel disease (IBD) patients have a higher threshold to scope, and the subsequent reassessment scope can happen anytime from 1 to 3 years depending on clinical indications. b) To omit the time frame in indication "*Inflammatory Bowel Disease (IBD) – 1 scope 3-6*	The CR for **SF702C, SF704C, SF705C, SF708C, SF710C, SF711C** and **SF807C** have been amended to reflect the proposed change as follows: "*Inflammatory Bowel Disease (IBD) - after initiation of and response to medical treatment for endoscopic evidence of healing".*

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		months after initiation of and response to medical treatment for endoscopic evidence of healing".	
2	<u>All colonoscopy procedures</u> **SF702C** – Colon, colonoscopy, fibreoptic with/without biopsy (2C) **SF704C** – Colon, colonoscopy, fibreoptic with removal of polyp(s) (single or multiple less than 1cm), with/without haemostasis (3A) **SF705C** – Colon, colonoscopy, fibreoptic with removal of polyps (multiple more than 1cm), with/without haemostasis (3B) **SF708C** – Colon, colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm), with/without haemostasis (4A) **SF807C** – Colon, colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm), with/without haemostasis (4A)	a) Propose to include "*family history of colorectal cancer (CRC)*" under indications for colonoscopy codes. b) Current Clinical Practice Guidelines (CPGs) recommend that individuals with a first-degree relative diagnosed with CRC are considered higher-risk and should undergo screening via colonoscopy, rather than the Faecal Immunochemical Test (FIT) recommended for the general population. There is therefore a clinical distinction between these two groups: while it may be appropriate for screening colonoscopies in the general population to remain non-claimable given the availability of FIT as an alternative, the same rationale does not apply to individuals with a family history of CRC, for whom colonoscopy is the clinically recommended screening modality. c) We recognise that the current policy position treats colonoscopies performed in the absence of symptoms or a positive FOBT as "screening" procedures, which are presently not subsidised or claimable. However, we respectfully highlight that this creates a discordance between clinical recommendations and claims policy for this specific higher-risk group. We therefore request that MOH consider recognising family history of CRC as a distinct claim indicator to better align policy with clinical practice. We also wish to flag that this matter may warrant broader consideration by MOH regarding whether international guidelines supporting colonoscopy screening for higher-risk individuals should be factored into the approval of MediShield Life and Medisave claims for this indication.	Specifically, for TOSP procedures, MediShield Life/MediSave claims for colonoscopies done for general health screening purposes (i.e. where the patient does not present with medical indications or complaints) are not allowed, with the exception of recommended screening colonoscopies (only for individuals aged 50 and above) which are covered by MediSave.
		a) The following indication should be added for all colonoscopy procedures: i. Raised faecal Calprotectin with abdominal symptoms in patient	The proposed change has been incorporated into the CR, under the indications for all colonoscopy procedures i.e. **SF702C, SF704C, SF705C, SF708C** and **SF807C.**

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		with suspected inflammatory bowel disease.	
		a) For surveillance colonoscopies where no polyp is detected and in the absence of illness, may this be considered as screening/diagnostic? Will ICD-10 diagnosis be Z codes?	Surveillance colonoscopies are not screening colonoscopies. Surveillance colonoscopies are performed on patients with a history of gastrointestinal conditions, to monitor for recurrence or progression of precancerous or cancerous lesions.
		a) For surveillance colonoscopy, propose to include clinical indication "*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*" at frequency "*1 scope at 1 year following completion of neoadjuvant therapy*".	The proposed change has been incorporated into the CR, under the indication for surveillance colonoscopy for **SF702C, SF704C, SF705C, SF708C** and **SF807C.**
3	**SF708C** – Colon, colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm), with/without haemostasis (3C) **SF807C** – Colon, colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm), with/without haemostasis (4A)	a) When a primary endoscopist performs a colonoscopy and finds an advanced or flat polyp requiring endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD), the patient is referred to an advanced endoscopist who are skilled to perform these procedures. EMR and ESD are therefore typically performed within weeks of the primary colonoscopy. b) For SF708C EMR and SF807C ESD, to allow 2-3 endoscopic procedures within weeks of each other.	The proposed change has been incorporated into the CR, under the indications for **SF708C** and **SF807C**, as follows: "*A repeat colonoscopy for polyps that cannot be removed by conventional polypectomy*" The CR are not exhaustive and deviation from CR, including frequency, is allowed if clinically justifiable. The treating doctor should inform his patient and retain relevant documentation to provide justification should the claim be picked up for adjudication.
4	**SF705C** – Colon, colonoscopy, fibreoptic with removal of polyps (multiple more than 1cm), with/without haemostasis (3B)	a) There is no TOSP code for removal of single polyp with size between 1cm to 3cm.	**SF704C** (3A) Colon, colonoscopy, fibreoptic with removal of polyp(s) (single or multiple less than 1cm), with/without haemostasis, may be used for single polyp removal with size 3cm or less. The TOSP Review Committee will consider updating the descriptor to make it clearer in the upcoming review cycle. <u>Other relevant codes are:</u> **SF705C** – Colon, colonoscopy, fibreoptic with removal of polyps (multiple more than 1cm), with/without haemostasis (3B)

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			SF708C – Colon, colonoscopy with endoscopic mucosal resection (EMR) of large polyps (>3cm), with/without haemostasis (3C) **SF807C** – Colon, colonoscopy with endoscopic submucosal dissection (ESD) of large polyps (>3cm), with/without haemostasis (4A)
5	**SF702C** – Colon, colonoscopy, fibreoptic with/without biopsy (2C)	a) We seek clarification on whether inpatient endoscopic procedures are claimable where the scope is clinically warranted by findings arising during an admission for a separate primary condition, and the indication for endoscopy does not correspond to any condition listed under the approved Inpatient Claim Indicators (e.g. a patient admitted for a mechanical fall but found to have unexplained bacteraemia or dyspepsia who is subsequently referred for endoscopic evaluation). If such scenarios are not currently accommodated, we request that MOH consider broadening the Inpatient Claim Indicators accordingly.	The CR are not exhaustive. They are derived from clinical evidence and existing practices to ensure MSHL can continue to cover medically necessary treatments in a sustainable manner and at affordable premium. Deviation from CR is allowed if clinically justifiable. The treating doctor should inform his patient and retain relevant documentation to provide justification should the claim be picked up for adjudication.
6	<u>All sigmoidoscopy procedures</u> **SF710C** – Colon, sigmoid, sigmoidoscopy (flexible), fibreoptic with/without biopsy (1B) **SF711C** – Colon, sigmoid, sigmoidoscopy with polypectomy with biopsy (1C)	a) For surveillance sigmoidoscopy, propose to include clinical indication "*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*" at frequency "*1 scope every 3 to 6 monthly for the first 2 years, followed by 6 monthly for the next 3 years*".	The proposed change has been incorporated into the CR, under the indication for surveillance sigmoidoscopy for **SF710C** and **SF711C.**
Oesophagogastroduodenoscopy (OGDS) Procedures			
7	**SF701I** – Intestine/stomach, upper GI endoscopy with/without biopsy (3C) **SF700I** – Oesophagus/stomach, upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of	a) Eosinophilic oesophagitis appears in initial gastroscopy but should also be allowed for monitoring of treatment as per the ACG 2025 guidelines, which states, *the general approach is to add a food or food group back for 6–8 weeks and repeat an endoscopy.* In reality, most patients are reluctant to undergo such intensive endoscopy but the guidelines set the standard of care and should	The proposed change has been incorporated into the CR, under the indications for subsequent gastroscopy for **SF701I** and **SF700I**, as follows: *"Eosinophilic oesophagitis with frequency of as needed after adding a food or food group back for 6-8 weeks"*

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	bleeding lesions/ injection of varices/ removal of single polyp (2C)	provide a framework for those who wish at least can be funded accordingly. b) Eosinophilic oesophagitis should be added as an indication for subsequent gastroscopy.	
		a) We propose adding the following claim indicators: I. Paraneoplastic work up (GED, cutaneous vasculitidis etc) II. For subsequent gastroscopy in eosinophilic oesophagitis, 2-3 months from post treatment re-evaluation +/- annually	The proposed change has been incorporated into the CR, under the indications for **SF701I** and **SF700I**, as follows: *"Paraneoplastic work up (GED, cutaneous vasculitidis etc)"* *"Eosinophilic oesophagitis with frequency of as needed after adding a food or food group back for 6-8 weeks"*
		a) Propose to remove indication "*Abnormal microRNA blood test result (e.g.GastroClear test)*" as it is a screening test in absence of symptoms.	An abnormal microRNA blood test result (e.g. GastroClear) warrants further diagnostic evaluation via gastroscopy. The indication will be retained in the CR for **SF701I** and **SF700I**.
		a) We propose adding the following claim indicators: I. Assessment for foreign bodies II. Assessment for oesophageal perforation III. Bariatric surgery complications including weight regain, dumping syndrome, or other side effects related to primary bariatric surgery IV. Assessment before or after endoscopic sleeve gastroplasty (SF815S) and V. Perioperative upper gastrointestinal (UGI) procedures.	The proposed changes have been incorporated into the CR, under the indications for **SF701I** and **SF700I.**
8	**SF808E** – Oesophagus/ gastroscopy with therapy e.g., APC fulgarisation of tumour (3C)	a) As there is no specific code for complex upper GI haemostasis e.g. bleeding ulcers, the following indication should be added for SF808E: i. Endoscopic haemostasis of upper GI bleeding e.g. bleeding duodenal ulcers requiring endoscopic therapy	The proposed indication is listed under **SF700I.**
9	**SF700I** – Oesophagus/stomach, upper GI endoscopy with polypectomy/ removal of foreign body/diathermy of bleeding lesions/ injection of varices/ removal of single polyp (2C)	a) Some endoscopists may use this code for removal of a single small polyp via biopsy, which would not be appropriate.	As the code does not specify a criteria for size, its use would not be restricted to any polyp size.

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10	**SF700E** – Oesophagus/stomach, gastroscopy and dilatation (3A)	a) We perform OGD oesophageal dilatation for oesophageal strictures (due to anastomotic, caustic ingestions). These are repeated procedures, done at intervals ranging from every 4 weeks to 6 months. Can this code be included in CR?	**SF700E** has been subsumed under **SF807E** (3A) Upper/lower GI, endoscopy/imaging guided stent placement.
11	**SF701I** – Intestine/stomach, upper GI endoscopy with/without biopsy (1B)	a) We seek clarification on whether cellular atypia falls within the scope of "dysplasia" as an approved Claim Indicator, given that the two terms are not always synonymous in clinical and pathological practice and may be interpreted inconsistently across institutions. If cellular atypia is not considered equivalent to dysplasia for claims purposes, we propose that it be included as a separate approved indication under SF701I.	The proposed change has been incorporated into the CR, under the indications for surveillance gastroscopy for **SF701I.**
		a) We propose adding post-resection surveillance for neuroendocrine tumours and gastric cancer as approved Claim Indicators, in alignment with the existing approved indication for "previous treatment for oesophageal cancer".	The proposed change has been incorporated into the CR, under the indications for surveillance gastroscopy for **SF701I**, as follows: ***"****Post-resection surveillance for upper gastrointestinal cancer"*
		a) We note that the current claim condition for "History of Sporadic Adenomas" stipulates only one claimable scope at one year following resection of adenomatous or dysplastic polyps, with no provision for further downstream surveillance. As ongoing surveillance beyond one year is consistent with evidence-based clinical practice, we suggest that MOH consider extending the claimable surveillance framework to accommodate subsequent surveillance intervals.	The CR are not exhaustive and deviation from CR, including frequency, is allowed if clinically justifiable. The treating doctor should inform his patient and retain relevant documentation to provide justification should the claim be picked up for adjudication.
		a) Can the indication "*Evaluation of dyspepsia*" be more specific by rephrasing to "*Dyspepsia for more than 2 weeks that does not respond to medical therapy for at least 2 weeks*" or **"***Unexplained or uninvestigated dyspepsia***"**	The proposed change has been incorporated into the CR, under the indications for **SF701I**, as follows: "*Evaluation of dyspepsia for more than 2 weeks or relapses after cessation of treatment".*
		a) Can the indication "Eosinophilic gastritis" be more specific by rephrasing to "Gastritis for more than 2 weeks that does not	As eosinophilic gastritis is a diagnosis that is confirmed after gastroscopy is performed, it has been removed as a clinical indication for initial gastroscopy,

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		respond to medical therapy for at least 2 weeks"?	and incorporated under the indications for subsequent gastroscopy in the CR for SF701I as follows: "Eosinophilic gastritis with the frequency of as needed".
		a) To consider adding "assessment before and after oesophageal surgery" under indications. This will cover our TOF repair patients.	The proposed change has been incorporated into the CR, under the indications for **SF701I.**
		a) For paediatric patients, biopsy to obtain tissue from H. Pylori culture can be done prior to treatment (not necessarily after failed eradication therapy as drafted in CR) as paediatric guidelines recommend biopsy-based diagnosis prior to treatment.	The CR are not exhaustive and deviation from CR is allowed if clinically justifiable. The treating doctor should inform his patient and retain relevant documentation to provide justification should the claim be picked up for adjudication.
12	**SF704E** – Oesophagus/ stomach/colon, gastrointestinal endoscopy, ablative treatment (3A)	a) We propose adding endoscopic ablation of post-bariatric surgery anatomy, such as dilatation of gastrojejunostomy, as an approved indication. b) Additionally, the term "ablative treatment" is not explicitly defined, and we seek clarification on what constitutes "ablative treatment" for claims purposes. We suggest that MOH could provide a precise definition or a non-exhaustive list of qualifying procedures to ensure consistent interpretation and application across institutions.	The proposed indications have been incorporated into the CR, under the indications for **SF704E.** Feedback to define "ablative treatment" will be surfaced to the TOSP Review Committee for their consideration.
13	**SF705E** – Oesophagus/intestine/stomach, upper GI endoscopy with endoscopic submucosal dissection (3C)	a) We propose differentiating lesions of the stomach (currently Table 3C), duodenum (Table 4A), and oesophagus (Table 4A) as approved indications and to reflect the complexity of the procedures.	This has been surfaced to the TOSP Review Committee for their consideration at the next review cycle.
14	**SF807E** – Upper/lower GI, endoscopy/imaging guided stent placement (3A)	a) We propose adding bleeding as an approved indication, and separately, the placement of diagnostic devices for investigation of foregut pathologies under indication "Insertion of prosthesis".	The proposed indications have been incorporated into the CR, under the indications for **SF807E.**
		a) We propose adding variceal bleeding as an approved indication i.e. Danis stenting under fluoroscopic guidance	
Capsule Endoscopy Procedures			
15	**SF700C** – Capsule endoscopy (3A)	a) GERD is a prevalent condition typically managed through medical treatment. However,	The capsule used for wireless pH monitoring is distinct from the capsule used in capsule

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		some patients do not respond to standard therapy and require further evaluation to confirm if their symptoms are caused by acid reflux. A wireless pH capsule can measure oesophageal acid exposure to provide this necessary diagnostic clarity. This procedure is an established modality recommended by international guidelines, Lyon Consensus. b) The following indication should be added for SF718B: i. Gastroesophageal Reflux Disease (GERD) to be allowed up to once a year.	endoscopy for small bowel pathologies. Feedback on the inclusion of GERD as a claimable indication for **SF700C** will be surfaced to the TOSP Review Committee for consideration.
Endoscopic Retrograde Cholangiopancreatography (ERCP) & Endoscopic Ultrasound (EUS) Procedures			
16	**SF718B** – Bowels, endoscopic ultrasound without fine needle aspiration (2C)	a) Endoscopic ultrasonography (EUS) should be used in combination with MRI as the preferred screening modalities in individuals undergoing pancreatic cancer screening (this is not the same as the pancreatic abnormalities drafted in the CR), as supported by the AGA guidelines. b) The following indication should be added for SF718B: i. Pancreatic cancer screening	Specifically for TOSP procedures, MediShield Life/MediSave claims for such procedures done for general health screening purposes (i.e. where the patient does not present with medical indications or complaints) are not allowed, with the exception of recommended screening colonoscopies (only for individuals aged 50 and above) which are covered by MediSave.
		a) For this procedure, a common/frequent indication is for suspected choledocholithiasis. This may occasionally be in the setting of an asymptomatic patient who has abnormal laboratory test (obstructive jaundice) which raised the suspicion, but CT imaging showed a normal common bile duct (CBD) (as it has low sensitivity for radiolucent stones). b) The following indication should be added for SF718B: i. Suspected choledocholithiasis	The proposed change has been incorporated into the CR, under the indications for **SF718B.**
17	**SF717B** – Bowels, endoscopic ultrasound with fine needle aspiration (3A) **SF718B** – Bowels, endoscopic ultrasound without fine needle aspiration (2C)	a) There are occasional referrals for assessments of GI subepithelial lesions outside the specified regions of oesophagus, stomach, duodenum and rectum. For example, small bowel pathology or colonic (above rectum) subepithelial lesions that can either be reached with forward viewing EUS, or miniprobe. b) To rephrase "*Gastrointestinal tract lesions: Subepithelial lesions*	The proposed change has been incorporated into the CR, under the indications for **SF717B** and **SF718B**.

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		(oesophagus, stomach, duodenum, rectum)" to "*Gastrointestinal tract lesions: Subepithelial lesions".*	
18	<u>ERCP codes</u> **SF710B** – Endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy/removal of stone/insertion of biliary stent (3C) **SF711B** – Bile duct, endoscopic retrograde cholangiopancreatography (ERCP) (3A) **SF712B** – Bile duct/gall bladder, endoscopy, endoscopic sphincterotomy +/- extraction of stone	a) We propose adding "*abnormal investigation findings suggestive of biliary or pancreatic pathology*" as an approved indication.	The CR are not exhaustive. They are derived from clinical evidence and existing practices to ensure MSHL can continue to cover medically necessary treatments in a sustainable manner and at affordable premium. Deviation from CR is allowed if clinically justifiable. The treating doctor should inform his patient and retain relevant documentation to provide justification should the claim be picked up for adjudication.