Responses to Clinical Feedback

S/N	TOSP Code	Feedback	MOH's Reply
1	**General Feedback**	• The indications are too specific. The phrase *'Including but not limited to'* is mentioned but having a list may make the administration feel like they need to conform to the list. • Claims indications are quite prescriptive. Clause for appeal should be stated. • Claims Rules not to be clinical practice guidelines. Yet they limit claims on certain scenarios. E.g., the need for 4 or more documented episodes of adenoiditis in the prior 12 months for children for adenoidectomy. That will mean that the patient will have to undergo 4 scopes first before surgery. Guidelines should have some flexibility.*	MSHL Claims Rules (CR) were with relevant specialists from both public and private sectors and aligned with prevailing evidence-based literature, clinical practice, and cost-effective guidelines. The rules have also been verified against past claims to ensure that that large majority of MSHL claims are covered. As such, CR should generally not incumber doctors' current practices The rules are also not absolute, and doctors may deviate from the CR when they have a sound clinical rationale for doing so. Should such cases be picked up for adjudication by MOH, post claim submission, the doctor who submitted the claim will be approached for clarification on the rationale for deviation. The anonymised clinical information provided will be sent to a panel of 3 to 5 relevant specialists appointed by the MSHL Council for review. Claims will be allowed if the deviation is deemed medically necessary for the patient. If the panel disagrees with the clinical justifications provided, the doctor and his patient may, within 30 working days of receiving the panel's assessment, submit new clinical information to the panel for reconsideration. Any treatments or items assessed to be inappropriate will be rejected. **NB: While the Workgroup (WG) attempted to avoid creating clinical guidelines, the criteria listed are from internationally accepted expert recommendations and are meant as a form of guidance to clinicians rather than strict requirements.*
		• For patients who do not fulfil criteria for surgery, and surgical intervention is not performed, is the doctor then not held liable if a complication of the disease occurs? • Certain investigations not necessary before surgery e.g., SPT to proof allergy is not necessary as the history and examination will point to the diagnosis. Using it as a criterion will add healthcare cost unnecessarily. Patient's preference for surgery should be taken into consideration.	Doctors should continue to provide treatment based on clinical judgement. Patient's preference for surgery can be considered, however the surgeon is responsible for counseling the patient on forms of non-invasive treatment before proceeding with surgery, and this should be clearly documented in the clinical notes. Where a patient requests to proceed with a procedure which deviates from the CR and the said procedure is not medically justifiable, proper clinical and financial counselling should be done. The patient should be informed that the procedure will not be claimable under MSHL and likely not covered under IP.

2	**SM700A (2C)** ADENOIDS, VARIOUS LESIONS, REMOVAL	Regarding the number of documented purulent discharge, can it also be by the paediatrician? There are circumstances where some children require tonsillectomy, but adenoids are not evaluated in clinic prior to surgery due to children who are uncooperative with a nasoscope on clinic (sensory children, autism etc.), in these cases situation would arise for adenoids to be evaluated with a nasoscope when child is under GA with a view of adenoidectomy. I.e., Tonsillectomy, nasoendoscopy KIV adenoidectomy. In these cases, are we able to code for nasoendoscopy with the adenotonsillectomy procedure?	Episodes of recurrent purulent rhinorrhea can be documented by the paediatrician or any clinician. Nasoendoscopy (SM700N) will be allowed to be submitted with adenotonsillectomy (SM700A) under GA for paediatric cases due to uncooperativeness or special needs. This is reflected in pg. 25 of the CR document.
		<u>Clinical Indications</u> • In children, adenoidectomy is also indicated if there is CRS (sinusitis symptoms for more than 12 weeks) with adenoid hypertrophy and failure of medical therapy. So may also be 1 prolonged episode rather than 4 recurrent episodes of acute sinusitis. • Suggest to include: '*Photo documentation of adenoid hypertrophy'*	The clinical indications have been amended to reflect the proposed changes.
3	**SM831E (1B)** EAR, TYMPANIC MEMBRANE, UNILATERAL, MYRINGOTOMY WITHOUT TUBE	<u>Clinical Indications</u> Suggest to include: (i) Patients for salvage intratympanic steroid injection after failed oral steroid treatment for sudden sensory neural hearing loss. (ii) Photo documentation of OME, type B tympanogram, conductive hearing loss, where applicable.	(i) **SM839E (2A)** should be used for intratympanic steroid injection. (ii) It is not necessary to include photo documentation. Clinician's assessment of the patient based on presenting symptoms will be sufficient.
4	**SM700I (1C)** INFERIOR TURBINATE REDUCTION (SUBMUCOUS DIATHERMY/ RADIO-FREQUENCY)	Suggest to reword *'Hypertrophy of inferior turbinates'* to *'Nasal obstruction secondary to 'hypertrophy of inferior turbinates.'*	*'Hypertrophy of inferior turbinates'* is self-explanatory and would suffice.
5	**SM711L (2C)** LARYNGO-SCOPY WITH REMOVAL OF TUMOUR/ LESIONS	As a therapeutic procedure for vocal cord lesions, this Table Code is not representative of the training or complexity. It should be Table 3A and above.	Comments have been surfaced to TOSP committee for review.
6	**SM716L (1B)** LARYNX, VARIOUS LESIONS,	Examination of the larynx under panendoscopy for cancer evaluation requires an esophagoscopy which is a 2C operation and procedure. Can this	Yes, SM716L can be submitted with SF701I INTESTINE/STOMACH, UPPER GI ENDOSCOPY WITH/WITHOUT BIOPSY (1B).

	DIRECT LARYNGO-SCOPE EXAMINATION W/WO BIOPSY	procedure be claimed with that? If not, to specify.	
7	**SM700N (1A)** NOSE, NASOENDOSCOPY/ NASOPHARYNGOLARYNGOSCOPY (DIAGNOSTIC, SINGLE, DURING A 90-DAY PERIOD)[1]	<u>Clinical Indications</u> Suggest to include: a) Acute (not just chronic) sinonasal symptoms. The presence of purulent discharge on scope (not just patient-reported) helps with deciding whether we give antibiotics. b) Nasal obstruction due to posterior septal deviation that can't be visualised on anterior rhinoscopy. c) Evaluation of all sorts of clear rhinorrhea d) Anterior, not just posterior epistaxis e) All nasopharynx/ oropharynx/ hypopharynx diseases f) Patients with eustachian tube dysfunction g) For *'Initial diagnosis or interval surveillance of sinonasal neoplasms'* - to be more specific and to include evaluation of upper aerodigestive tract neoplasms (nasal cavities, postnasal space, pharynx, larynx) and for evaluation of thyroid nodules. Should not include the exception of *'not due to septal deviation'* as patients with nasal valve collapse/stenosis/blockage due to caudal or high septal deviation do require nasoendoscopy for diagnosis and documentation (the insurance companies are increasingly asking for photo and video documentation of endoscopy views for these). This assessment and documentation along with assessment and documentation of nasal airway before and after decongestion can only be done properly with nasal endoscopy. Hence all patients with nasal obstruction do require a nasal endoscopy. Often patients may have another pathology lurking in the posterior nasal cavity behind a deviated septum, which can only be diagnosed once an endoscopy has been performed.	The clinical indications have been amended to reflect the proposed changes.
		• Asymptomatic patients are referred to us with raised EBV serology/strong family history to exclude NPC. How do we reconcile this with one of the	The clinical indications have been amended to reflect the proposed changes.

[1] The frequency restriction of code applies irrespective of the specialist performing the procedure or medical institution at which the procedure is performed.

		exclusion criteria for nasoendoscopy? ('*Nasoendoscopy is not medically necessary as a screening tool in the evaluation of an asymptomatic individual*') • In medically indicated asymptomatic patients with specific risks factors e.g., family history of head and neck cancers, elevated EBV levels obtained from general health screening, nasoendoscopy should be allowed.	There should be clear documentation of patient risk factors i.e., family history of EBV or raised EBV titres. If EBV serology was not obtained prior, it should be done if necessary, together with the screening nasoendoscopy. However, any scope performed under 90 days frequency cap rules, should be submitted under the new Minor Surgical Procedures (MSP) code, SM726N, which is not MSHL or MediSave (MSV) claimable.
		What if a respiratory physician refers a case of chronic cough for ENT clearance, is nasoendoscopy considered medically necessary and, therefore, claimable?	Cases of chronic cough for ENT clearance are considered clinically appropriate for nasoendoscopy. However, any scope performed under 90 days frequency cap rule, should be submitted under the new MSP code, SM726N, which is not MSHL or MSV claimable (see below).
		<u>Frequency</u> • Can we confirm that we can charge for a new nasoendoscopy procedure every 90 days? • What does *'repeat nasoendoscopy is considered medically necessary'* mean in terms of using SM700N. Does it mean we can charge again even if it is within the 90 days? • Repeat nasoendoscopy should be allowed for close monitoring of head and neck cancers, especially in the first 3 years post treatment because the risk of recurrence is highest during this period. • What if the patient has a different nose problem within 90 days and needs a nasoendoscopy for evaluation?	SM700N allows for 1 claim every 90 days. SM700N has a TOSP Committee imposed frequency cap that will be carried over in the CR document. Any repeat or surveillance nasoendoscopies done within 90 days should be submitted under the new TOSP 2021/2022 code: **SM726N (MSP)** NOSE, NASOENDOSCOPY/NASOPHARYNGOLARYNGOSCOPY (REPEAT EXAMINATIONS, DURING A 90-DAY PERIOD) <u>FOOTNOTE</u>: THIS CODE IS TO BE UTILISED FOR REPEAT EXAMINATIONS WITHIN 90 DAYS OF USING SM700N. For nasopharyngeal cancers and for new symptoms indicating a different disease from previous diagnosis, clinicians should perform the nasoendoscopy in line with good clinical practice. Should this claim be identified for adjudication post submission, the doctor who submitted the claim will be approached for clarification on the rationale for deviation. The anonymised clinical information provided will be sent to a panel of 3 to 5 relevant specialists appointed by the MSHL Council for review. Claims will be allowed if the deviation is deemed medically necessary for the patient. If the panel disagrees with the clinical justifications provided, the doctor and his patient may, within 30 working days of receiving the panel's assessment, submit new clinical information to the panel for reconsideration. Any treatments or items assessed to be inappropriate will be rejected

		• Patients may not tell us accurately whether they had nasoendoscopy within last 90 days. 90 days period should be for each ENT (as we will have records) and not for all/any ENT. • How is MOH going to oversee this 90-day limit on nasoendoscopy? Is there any punitive action if we inadvertently make a mistake?	The frequency restriction has been introduced to set a limit to the number of procedures claimable by MSV and MSHL due to previous excessive claims. The National Electronic Health Record (NEHR) or medical record system should be checked for the patient in addition to getting a history. However, should best effort fail, and the frequency cap be crossed, the doctor who submitted the claim will be approached for clarification on the rationale for deviation. The anonymised clinical information provided will be sent to a panel of 3 to 5 relevant specialists appointed by the MSHL Council for review. Claims will be allowed if the deviation is deemed medically necessary for the patient. If the panel disagrees with the clinical justifications provided, the doctor and his patient may, within 30 working days of receiving the panel's assessment, submit new clinical information to the panel for reconsideration. Any treatments or items assessed to be inappropriate will be rejected.
		For subsequent nasoendoscopies, although it is not claimable from Medisave, are we allowed to collect payment from the patient for facility fees, co-Phenylcaine spray, etc.?	Yes, medical institutions are allowed to collect payment for facility fees and medications where applicable.
		Suggestion for setting to be as Day Surgery unless patient is admitted prior.	WG has allowed claims for both inpatient and day surgery setting.
8	**[NEW CODE] SM726N (MSP)** NOSE, NASOENDO-SCOPY/NASO-PHARYNGO-LARYNGO-SCOPY (REPEAT EXAM, DURING A 90-DAY PERIOD)	May we know what table is SM726N? It sounds like a TOSP, meaning that patients (and doctors) can still claim from MediSave for repeat nasoendoscopic examinations within 90 days of first scope. If the purpose is to curtail indiscriminate charging of repeat scopes, a cheaper MSP code (not MediSave claimable) may be more appropriate.	SM726N will be introduced as an MSP code, which is not MSHL or MSV claimable. This code is to be utilised for repeat examinations within 90 days of using SM700N.
		Will SM726N (the new TOSP) be the code to be used for post-operative assessment? Will it include some frequency criteria – as to how many scopes can be done for a specified period for surveillance purposes?	Yes, any repeat or surveillance nasoendoscopies should be submitted under SM726N (MSP). There are no limits to the number of scopes that can be submitted under SM726N (MSP).
9	**SM713N (1B)** NOSE, VARIOUS LESIONS (POSTNASAL SPACE), DIRECT EXAMINATION WITH BIOPSY AND	There should be photo documentation of suspicious nasal tumors or polyps in clinical indications.	We will allow flexibility based on clinician's own judgement on the type of medical documentation required.

	NASENDO-SCOPY		
10	**SM714N (2C)** NOSE, VARIOUS LESIONS (TURBINATES), TURBINEC-TOMY/TURBI-NOPLASTY/ SUBMUCOUS RESECTION (W OR WO ENDOSCOPES)	<u>Clinical Indications</u> (i) Clinical indication 2b. '*Allergic history and testing have been performed where indicated'* - Allergic rhinitis testing may not be indicated in all patients if history and physical examination are definitive. Excessive use of allergy testing will drive up healthcare cost unnecessarily. (ii) Suggest to include: *'Successful trial of medications but patient does not want to rely on medications.'* (iii) There should be photo documentation.	(i) This clinical indication has been removed. (ii) This indication will not be included. However, patients should have had a trial of medications before surgery. (iii) We will allow flexibility based on clinician's own judgement on the type of medical documentation required.
11	**SM723N (5C)** NOSE, VARIOUS LESIONS, RHINOPLASTY (TOTAL) INCLUDING CORRECTION OF ALL BONY AND CARTILAGI-NOUS ELEMENTS	*'Correction/Reconstruction of the lower 2/3 and 1/3 of the nasal skeleton for':* Please clarify the meaning of '1/3 of the nasal skeleton'. Which third of the nasal skeleton is this referring to?	This indication has been reworded to: 'Correction/Reconstruction of the external cartilaginous nasal skeleton and nasal bony vault'.
		The clinical indication *'in the absence of appropriate trial of conservative medical management of symptoms'* should be reworded as *'in the absence of appropriate trial of conservative medical management of symptoms, where indicated'.*	WG is of consensus that in severe cases where nasal passages complete static obstruction, a trial of conservative medical management may not be indicated. Justification can be provided by medical documentation and photo/video evidence.
		What is the appropriate code for the following: (i) if nasal bones are osteotomised, spreader grafts and a columella strut is used; (ii) septal extension graft + alar rim grafts?	(i) **SM723N** (5C) NOSE, VARIOUS LESIONS, RHINOPLASTY (TOTAL) INCLUDING CORRECTION OF ALL BONY AND CARTILAGINOUS ELEMENTS (ii) **SM720N** (4C) NOSE, RHINOPLASTY, CORRECTION OF LATERAL/ALAR CARTILAGE AND/OR SEPTAL STRUT (INCLUDING ALL GRAFTS, EXTRACORPOREAL SEPTOPLASTY), RECONSTRUCTION OF NASAL VALVE(S), AND/OR EXTRANASAL CARTILAGE HARVEST
		What proof is required to show that a rhinoplasty is medically necessary?	Medical documentation of appropriate patient history, physical examination, and clinical photographs
		With regards to humpectomies not routinely qualifying for the code: I think we need to include an exception here. Patients with a tension nose deformity have very narrow nasal valves due to high and narrow nasal dorsum. These patients do require a humpectomy to lower the dorsum to improve the tension nose and hence improve the internal nasal valve angle and internal nasal valve area to help in improvement of nasal obstruction. Hence, we should reword this as: *Humpectomies for aesthetic improvement in the shape of the nose do not routinely qualify for this*	WG agrees that there may be isolated cases of humpectomies which may require SM723N. These cases are uncommon among the Singaporean population. Humpectomies must be medically justified by the clinician with evidence. Claims with valid clinical rationale will still be approved. The clinical indications will be reworded to: 'Humpectomies for aesthetic improvement in the shape of the nose do not routinely qualify for this code.'.

		code. However, there are exceptions where the patient has a tension nose deformity leading to narrowing of the internal nasal valve angles and area. Such patients will qualify for humpectomy under this code.	
		This code should be allowed for Day Surgery, Short Stay Ward	The setting has been amended to allow inpatient or day surgery.
		ENT specialists noted to code SM806E (EAR, DEFORMITY, COMPOSITE GRAFT) for Ear Cartilage Harvest or SC701T (Thorax, Coastal Cartilage, Harvest and Creation of Ear Cartilage Framework) for the Rhinoplasty procedure, where both bone and cartilage correction is being done. Would SM723N include extra nasal cartilage harvest? Please advise if it is an appropriate code to be used in this scenario. If no, what would be the most suitable code to be used?	Yes, the use of SM723N is appropriate in such cases. Feedback to include 'extra nasal cartilage harvest' as part of the TOSP descriptor has been surfaced to TOSP committee.
12	**SM724N (3B)** NOSE, VARIOUS LESIONS, SEPTOPLASTY/ SUBMUCOUS RESECTION	The clinical indication *'Nasal obstruction due to a deviated septum, not relieved by appropriate medical therapy'* should be reworded as *'Nasal obstruction due to a deviated septum, not relieved by appropriate medical therapy, where appropriate'.*	This clinical indication has been reworded to: *'Nasal obstruction due to a deviated septum, not relieved by medical therapy, where appropriate'.*
		Suggestion to include: *'Successful trial of medications but patient does not want to rely on medications.'*	WG is of consensus that it is not necessary to include this indication. However, if the patient refuses medical therapy, it will have to be clearly documented in the clinical notes.
13	**[NEW CODE] SM704S (1B)** SINUSES, NASAL, ENDOSCOPIC POST SINUS SURGERY TOILET/DEBRI DEMENT	May we know what table is SM704S? It sounds like a TOSP. Would a cheaper MSP code (not MediSave claimable) be more appropriate, to prevent indiscriminate charging and claiming from MediSave.	SM704S is tabled at 1B. Single claim will be allowed per episode of procedure(s).
		Regular nasal toilet is extremely important to achieve a good surgical outcome. This is done endoscopically at least once weekly to remove crust and blood clot to prevent synechiae. Intranasal pack is re-inserted into ethmoidectomy cavity after the nasal toilet. This is repeated till the wound has epithelised. Each session of nasal toilet done endoscopically can take up to 45 minutes. Hence, to permit surgeon to charge only once for nasal toilet after the surgery is not justifiable. Such complex nasal toilet procedure should be charged as per session. An analogy is the daily change of Eusol dressing for subcutaneous abscess wound after saucerisation is done, the surgeon charges for each change of Eusol dressing with wound cleaning.	Comments have been surfaced to TOSP committee for review.
14	**SM715S (3B)**	The proposition is for it not to be used with any other ENT TOSP. This is completely impossible. If for example, patient has a	The descriptor SM715S is deemed to be too non-specific in its current form and request has been raised to TOSP committee to review the

	SINUSES, NASAL, VARIOUS LESIONS, INTRANASAL OPERATION	concha bullosa which is obstructing the middle meatus, and also has inferior turbinate hypertrophy - does that mean that we cannot do both procedures at the same time? If so, then we might end up coding a higher table to do ethmoidectomy and MMA, even when not appropriate in this case. There are also many patients who require small sinus procedures in addition to say a septoplasty, such as trimming of the middle turbinate, or in cases who have had previous surgery, debridement of polyps or cleaning up of the ethmoid cavity.* If this is implemented, I am certain that this will have the undesired effect of forcing surgeons to code higher tables, for a small amount of work, which defeats the purpose of this whole exercise.	code. SM715S is also not the appropriate code for concha bullosa, middle turbinoplasty and polypectomy and these should utilize SM714N instead. **NB: If a single TOSP code can adequately describe the procedure, only 1 code should be used. For "staged" procedures, only the definitive surgery should be claimed. E.g., if a middle turbinoplasty was done to create access to the septum for septoplasty, only the septoplasty code should be submitted.*
		Here "any other ENT TOSP" would include all ENT TOSP (e.g., Tonsillectomy) or just TOSP for procedures limited to Sinuses?	The clinical indications have been amended as follows: *'Procedure must be limited to the sinonasal area',* and *'It is inappropriate to be claimed with any other sinonasal procedure.'.*
15	**SM701T (4B)** THROAT, UVULOPALATO PHARYNGO-PLASTY (U3P) W/WO TONSILLEC-TOMY	4B code is not commensurate with the complexity and risks associated with this surgery. It should be a 5A operation.	Comments have been surfaced to TOSP committee for review.
		Usually seen coded with SF809T 3A (Tongue, Various Lesions, Partial Excision). Please advise if this is appropriate coding.	It is appropriate to code SM701T with SF809T in a single surgical procedure, as partial excision of the tongue/ablation of the tongue is required to address the tongue base area obstruction.
16	**SM705T (3B)** TONSILS, VARIOUS LESIONS, REMOVAL W/WO ADENOIDEC-TOMY	<u>Setting</u> • Tonsillectomy has more risks of post-op bleed as well as need for more careful observation than e.g., adenoidectomy (SM700A 2C), yet tonsillectomy is recommended as day surgery while adenoidectomy has option of day surgery or overnight stay. The ENT is best placed to advise on this. • Option for claims should be flexible to allow for both day surgery and inpatient admission. E.g., tonsillectomy. As there are patient groups e.g., children. Special needs adults may need inpatient management. • Tonsillectomy as day surgery: young children may have feeding issues post-surgery and may need to have intravenous hydration. Close monitoring needed. Tonsil surgery should not be recognised to be a day surgical procedure.	Tonsillectomy without significant pre-existing conditions should be done as day surgery/ambulatory. Inpatient stay may be needed but should be justified and documented in the clinical notes. E.g., an elderly with significant pre-existing morbidities may require postoperative monitoring and inpatient stay may be allowed. The setting for SM705T and SM700A (adenoidectomy) have been adjusted to 'day surgery, with exceptions for the inpatient setting'. In paediatric cases, claims for inpatient and day surgery will be allowed.

		To include in criteria for inpatient admissions: *'Patients who are unable or unwilling to undergo LA for day surgery cases.'*	Tonsillectomy is done as GA, not LA. Inpatient admissions made purely based on the request of a patient, without any evidence of clinical necessity, are not claimable under MSHL.
17	**Other Procedures**	Use of Clarifix-Cryotherapy for chronic rhinitis for cryoablation of the posterior nasal nerve (PNN). Noted different codes used for this procedure by specialists – SK701F(2A) FACIAL, TRIGEMINAL NERVE BLOCK, NEUROLYTIC; SK740N(2B) PERIPHERAL NERVE, BLOCK, NEUROLYTIC (MORE THAN 2 NERVES). Please advise on the correct code for this procedure. Can this be coded separately with SM700I (1C) or SM714N?	Clarifix-Cryotherapy can utilize the proxy code SK701F or SK740N. These codes can be coded separately with either SM700I or SM714N. In general, no proxy codes are allowed, however the utilisation of proxy codes for Clarifix has been approved by TOSP Secy.