9 Anoscopy, Proctosigmoidoscopy, Flexible Sigmoidoscopy, and Colonoscopy

The focus of Chapter 9 is on anoscopy, proctosigmoidoscopy, flexible sigmoidoscopy, and colonoscopy procedures and all applicable recently revised guidelines for the CPT codes for these procedures.

Overview

There are multiple revisions in the CPT 2015 code set for the lower endoscopy section, such as clarification on the definition of proctosigmoidoscopy and sigmoidoscopy, and evaluation of ileoanal pouch, ileoscopy through ileostomy, colonoscopy through stoma and colonoscopy. However, the changes that apply to access through the anal approach will be discussed in this chapter, whereas those that apply to access via stoma are discussed in Chapter 8.

Endoscopy (44385-44386, 45300-45393, 45398)

See Tables 9-1, 9-2, and 9-3 for the specific CPT codes for small intestine pouch endoscopy, proctosigmoidoscopy, sigmoidoscopy (rigid, flexible) and colonoscopy. Two Healthcare Common Procedural Coding System (HCPCS) codes (**G0105** and **G0121**) were developed by the Centers for Medicare and Medicaid Services (CMS) to differentiate between screening and diagnostic colonoscopies for the Medicare population. Therefore, to report screening and diagnostic colonoscopies for services rendered to Medicare beneficiaries, see Table 9-4.

Table 9-1. CPT Codes for Endoscopy (45385-45386)

CPT Code	Code Descriptor
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple

Table 9-2. CPT Codes for Proctosigmoidoscopy (45300-45327)

CPT Code	Code Descriptor
45300	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
43307	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique

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45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
45317	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)

Table 9-3. CPT Codes for Sigmoidoscopy (45330-45350)

CPT Code	Code Descriptor
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334	Sigmoidoscopy, flexible; with control of bleeding, any method
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and postdilation and guide wire passage, when performed)
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and postdilation and guide wire passage, when performed)
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)
G0104	Colorectal cancer screening; flexible sigmoidoscopy

Table 9-4. CPT Codes for Colonoscopy (45378-45398)

CPT Code	Code Descriptor
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
45379	Colonoscopy, flexible; with removal of foreign body(s)
45380	Colonoscopy, flexible; with biopsy, single or multiple
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
45382	Colonoscopy, flexible; with control of bleeding, any method
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and postdilation and guide wire passage, when performed)
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	Colonoscopy, flexible; with transendoscopic balloon dilation
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and postdilation and guide wire passage, when performed)
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
45390	Colonoscopy, flexible; with endoscopic mucosal resection
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)

Table 9-5. HCPCS Codes for Colonoscopy

HCPCS Code	Code Descriptor
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

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Guidelines, Definitions, and Major Revisions for Colon Endoscopy

For CPT 2015, several of the definitions related to colon endoscopy were revised and some of the important terms and guidelines related to endoscopy were changed as well. See the following list for these changes.

- ***Proctosigmoidoscopy*** is the examination of the rectum and may include examination of a portion of the sigmoid colon.
- ***Sigmoidoscopy*** is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.
- ***Colonoscopy*** is the examination of the entire colon, from the rectum to the cecum, and may include examination of the terminal ileum or small intestine proximal to an anastomosis.
- ***Colonoscopy through stoma*** is the examination of the colon, from the colostomy stoma to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis.
- Report ileoscopy through stoma (**44380**, **44381**, **44382**, **44384**) for endoscopic examination of a patient who has an ileostomy. See Chapter 8 for the details.
- Report colonoscopy through stoma (**44388**-**44408**) for endoscopic examination of a patient who has undergone segmental resection of the colon (eg, hemicolectomy, sigmoid colectomy, low anterior resection) and has a colostomy.
- Report anoscopy, proctosigmoidoscopy, or sigmoidoscopy, as appropriate for endoscopic exam of a defunctionalized rectum or distal colon in a patient who has undergone colectomy, in addition to colonoscopy through stoma or ileoscopy through stoma, if both portions of the colon are examined on the same date or in same encounter.
- Report flexible sigmoidoscopy (**45330**-**45347**) for an endoscopic examination of a patient who has undergone resection of the colon proximal to the sigmoid (subtotal colectomy), and who has had an ileo-sigmoid or ileo-rectal anastomosis. The distinction between this and the previous two scenarios is the shorter length of the remaining colon and not just the absence of a cecum. A short scope can typically be utilized for these circumstances.
- Report pouch endoscopy codes (**44385** and **44386**) for endoscopic examination of a patient who has undergone resection of colon with ileo-anal anastomosis (eg, J-pouch). See Chapter 8 for details.
- Report colonoscopy (**45378**-**45398**) for endoscopic examination of a patient who has undergone segmental resection of the colon (eg, hemicolectomy, sigmoid colectomy, low anterior resection).

Major Revision 1

When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report code **45378** (colonoscopy) or **44388** (colonoscopy through stoma) with modifier **53** appended, and provide appropriate documentation.

✔ *Coding Tip for 45378 and 44388*

- The terminology "proximal to the splenic flexure" is no longer used; therefore, if the scope does not reach the cecum, modifier **53** should be appended to the claim, which only applies to screening or diagnostic. This rule only applies to code **45378** in the endoscopy section, which follows the CMS policy on screening colonoscopy. For detailed discussion about code **44388**, see Chapter 8. Physician documentation must clearly state how far the scope was inserted.

This convention addresses CMS policy regarding the allowed frequency of colonoscopy exams. If an incomplete colonoscopy is performed for screening purposes and a second procedure is performed to complete the exam, appending modifier **53** will ensure the contractor pays for the second (complete) procedure and prevent a denial based on the exam being "premature" (eg, less than 10 years if low-risk screening, 2 years for high-risk screening). For a Medicare patient, an HCPCS G-code

(**G0121** for average risk, **G0105** high risk) should be submitted with modifier **53**, which should be handled by the contractor as though code **45378** was submitted.

Note that screening examinations that become therapeutic (eg, a polyp is found and removed, a lesion biopsied, etc.) must be reported with special modifiers. If a screening procedure is converted into a therapeutic procedure, modifier **33** should be appended for the commercial payer and modifier **PT** for Medicare to trigger preventive benefits coverage. Appending the appropriate modifier for both Medicare and commercial payers, results in the deductible being waived. Commercial payers will also waive the copayment. Due to an oversight in the Affordable Care Act by Congress, Medicare beneficiaries are still responsible for paying the copayment when a screening colonoscopy also involves the removal of polyps or other tissue during the screening encounter. A legislative solution to this oversight has been repeatedly introduced but never passed by Congress. This is a top advocacy priority for ASGE. Unfortunately, this technicality in current law comes as a surprise to most patients, resulting in frustration by the patients when they receive a bill for the copayment of a screening colonoscopy that turned therapeutic. As of 2017, Medicare patients may also elect to have propofol sedation provided by anesthesia personnel for colorectal cancer screening exams, not limited by policies of restricted medical circumstances. Similar to the colonoscopy service, if screening becomes therapeutic the deductible but not the copayment for anesthesia services will be waived.

Major Revision 2

If therapeutic colonoscopy (**44389**-**44407**, **45379**, **45380**, **45381**, **45382**-**45398**) is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier **52** appended and provide the appropriate documentation.

✔ *Coding Tips for Therapeutic Colonoscopy*

- The terminology "proximal to the splenic flexure" is no longer used; therefore, if the scope does not reach the cecum, modifier **52** should be appended to the claim. This applies to therapeutic procedures only (i.e., any colonoscopy codes in the family that are not the parent or diagnostic code).
- Physician documentation must clearly state how far the scope was inserted.
- Modifier **52** would be appended to the facility claim.

Modifier **52** provides a mechanism to report an incomplete procedure because the definition of a complete colonoscopy, as noted above, includes the passage of the colonoscope to cecum or colon-small intestine anastomosis. Ordinarily, modifier **52** is applied to a reduced service and at the discretion of the physician; and this would apply, for example, when a physician elects to deal with a lesion in the transverse colon (eg, endoscopic mucosal resection of a polyp or submucosal injection of a recent polypectomy site where cancer was identified in the polyp), but elects not to advance the scope to the cecum because the complete exam was done shortly before, and did not seem medically necessary. However, modifier **52** must also be reported when there is an involuntary inability to reach the cecum/small intestine anastomosis (eg, an obstructing lesion in transverse or ascending colon, anatomy variations prohibiting passage, excessive pain or physiologic instability developing before the exam is complete). The GI societies explained that, in many of these circumstances, the physician work is unusually complex if extra time and effort are expended in trying to negotiate a difficult colon. This leads to the peculiar circumstance in which a physician could report modifier **52**, based on the definition above, and modifier **22** for the same service to indicate the increased procedural services. Documentation must support the substantial additional work and the reason for the extra work. At this time, despite several years of the definitions in place, it is still unknown how Medicare or other payers are addressing the use of modifier **52** for any of these circumstances. Feedback to the GI societies about the unintended consequences from this direction from the CPT coding instructions is requested.

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Rigid Scope Exams

Gastroenterologists rarely perform rigid scope exam of proctosigmoidoscopy and anoscopy. With few exceptions, gastroenterologists only report diagnostic proctosigmoidoscopy and anoscopy. For this reason, discussions regarding proctosigmoidoscopy and anoscopy in this chapter will be limited to single diagnostic codes (**45300**, **46600**) (Table 9-6). The modalities of therapy that apply to the sigmoidoscopy codes will be discussed within the section of colonoscopy codes **45378** et seq., because the nuances about coding colonoscopy procedures apply to the flexible sigmoidoscopy family of codes as well.

Code series **45303**-**45321** has the same structure as the anoscopy codes, including the distinction between the removal of single and multiple lesions having different codes, which differs from the upper GI endoscopy and colonoscopy families. Although the flexible sigmoidoscopy, colonoscopy, and colon through stoma codes had extensive revisions and RUC revaluation, the anoscopy and rigid sigmoid codes have not undergone this review.

Note that moderate sedation is considered inherent to the procedure for the more complex therapeutic codes and not for the base diagnostic code.

45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*

Code **45300** should be used to report not only a visual inspection of the rectal mucosa, which may include brushings or washings if performed (eg, taking a swab for culture or viral testing), but a brushing of a possible viral or malignant lesion as well.

✔ *Coding Tips for 45300*

- The work for code **45300** is included in the sigmoidoscopy and colonoscopy codes. Only the most extensive endoscopic procedure should be billed.
- The work for code **45300** is bundled into every hemorrhoid procedure and, therefore, it should not be billed separately.
- Note that only the parent code never included moderate sedation, i.e., moderate sedation was never inherent to the procedure, and, if provided, the code **99152** would apply rather than **G0500** for Medicare or for commercial payers. (See Chapter 16 for more information about moderate sedation.)[1]

Table 9-6. CPT Codes for Anoscopy (46600-46615)

CPT Code	Code Descriptor
46000	Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed
46604	Anoscopy; with dilation (eg, balloon, guide wire, bougie)
46606	Anoscopy; with biopsy, single or multiple
46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple
46608	Anoscopy; with removal of foreign body

46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
46611	Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique
46614	Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
46615	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
0288T	Anoscopy; with delivery of thermal energy to the muscle of the anal canal (eg, for fecal incontinence)

Code **46600** should be used to report not only a visual inspection of the anal canal or distal rectal mucosa (eg, taking a swab for culture or viral testing), but a brushing of a possible viral or malignant lesion as well.

The code descriptors of the anoscopy series have not been updated with the terminology conventions that were applied throughout most other GI endoscopy codes; therefore, some older language has been retained only in this particular section.

Diagnostic endoscopy is always inherent to (i.e., included in) a therapeutic endoscopy. If an anoscopy with directed submucosal injection of bulking agent for fecal incontinence is done, then use **0377T**, but this is not reported in conjunction with the anoscopy code **46600**.

46600 *Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)*

*(Do not report **46600** in conjunction with **46020, 0249T, 0377T**)*

*(For diagnostic high-resolution anoscopy [HRA], use **46601**)*

✔ *Coding Tips for 46600*

- The work for code **46600** is included in sigmoidoscopy and colonoscopy codes. Only the most extensive endoscopic procedure should be billed.
- The work for code **46600** is bundled into every hemorrhoid procedure and, therefore, it should not be billed separately.[2]

The other codes in the endoscopy section that are performed infrequently by gastroenterologists include the following codes.

46601 *Anoscopy; diagnostic high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed*

*(Do not report **46601** in conjunction with **69990**)*

46607 *Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple*

*(Do not report **46607** in conjunction with **69990**)*

These two codes are procedures that use magnification techniques, and they are meant to be used primarily for high-risk human immunodeficiency virus (HIV)/human papillomavirus (HPV) patients. It is important to note that these codes were not established to report optical endomicroscopy (used for an anorectal junction exam), which should be reported with an unlisted CPT code (**46999** for anus, **45999** for rectum).[3]

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The **46610**-**46612** code series is non-traditional to gastroenterologists because there is a distinction between single lesion therapy and multiple lesion therapy. Although the single lesion therapy is reported with a different code for the snare cautery removal of a lesion, code **46612** applies to all of these modalities, including snare removal.[4]

Flexible Scope Exams: Sigmoidoscopy and Colonoscopy

Prior to 2015, description of sigmoidoscopy and colonoscopy refers to the intent of the original procedure and not just where the scope is advanced. Essentially, the previous CPT code set took into consideration the location or circumstances of the intended complete colonoscopy and even if the scope was not passed beyond the splenic flexure the procedure could still be reported as a colonoscopy albeit with a modifier appended. In contrast, since CPT 2015, guidelines on this section instruct that sigmoidoscopy is reported when the scope is not passed beyond the splenic flexure, regardless of intention. If the intention is to perform a colonoscopy, but the exam is not complete to the cecum or colon-small intestine anastomosis, then the colonoscopy should be reported with the appropriate modifier, depending on whether the exam was screening or diagnostic (modifier **53**, if incomplete, i.e., for unforeseen circumstances) or therapeutic or surgical (modifier **52**).

Sigmoidoscopy

The definitions were revised for CPT 2015 guidelines in the GI section are directly reproduced below and it is important to note the distinctions between the previous definitions and the current. (See Tables 9-1 to 9-2.)

- ***Sigmoidoscopy*** is the examination of the entire rectum, sigmoid colon and may include examination of a portion of the descending colon.
- ***Colonoscopy*** is the examination of the entire colon, from the rectum to the cecum, and may include examination of the terminal ileum or small intestine proximal to an anastomosis.
- Report flexible sigmoidoscopy (**45330**-**45347**) for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure. Report flexible sigmoidoscopy (**45330**-**45347**) for endoscopic examination of a patient who has undergone resection of the colon proximal to the sigmoid (eg, subtotal colectomy) and has an ileo-sigmoid or ileo-rectal anastomosis.
- Report pouch endoscopy codes (**44385**, **44386**) for endoscopic examination of a patient who has undergone resection of colon with ileo-anal anastomosis (eg, J-pouch).
- Report proctosigmoidoscopy (**45300**-**45327**), flexible sigmoidoscopy (**45330**-**45347**), or anoscopy (**46600**, **46604**, **46606**, **46608**, **46610**, **46611**, **46612**, **46614**, **46615**) as appropriate for endoscopic examination of the defunctionalized rectum or distal colon in a patient who has undergone colectomy, in addition to colonoscopy through stoma (**44388**-**44408**) or ileoscopy through stoma (**44380**, **44381**, **44382**, **44384**) if appropriate.
- When bleeding occurs as a result of an endoscopic procedure, control of bleeding is not reported separately during the same operative session.

Note that the instruction control of bleeding is not a new idea; it is common to all endoscopy code series that underwent terminology revision from 2012 to 2014. This change in terminology is meant to clarify frequently asked questions.

45330 *Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)*

*(Do not report **45330** in conjunction with **45331-45342, 45346, 45347, 45349, 45350**)*

✔ *Coding Tips for 45330*

- Codes **45330** and **45331**. did not inherently include moderate sedation, unlike the other codes in the flexible sigmoidoscopy family. As of 2017, when it is medically necessary to utilize moderate (conscious) sedation to perform the work of code **45330**, the appropriate code may be reported separately, which is usually **99152**, Moderate sedation services (other than those services described by codes **00100**-**01999**) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of service, age 5 years or older. Appropriate documentation should always indicate the unusual situation that warrants the sedation and the time expended between starting the first dose of sedation through the time the patient is stable to move to recovery.
- Included in the colonoscopy codes because only the most extensive endoscopic procedure should be billed.
- Do not report code **45330** when a colonoscopy cannot be completed. Refer to the definitions regarding the proper reporting of either modifier **52** or **53**.[5]

G0104 *Colorectal cancer screening; flexible sigmoidoscopy*

HCPCS code **G0104** was developed by CMS as an alternative to billing the CPT diagnostic code. Per CMS rules, screening sigmoidoscopy is allowed once every 4 years after the beneficiary has reached 50 and older. Some commercial payers will also accept **G0104**. There is no HCPCS code for high-risk screening sigmoidoscopy.

The various modalities described in the following codes are discussed in more detail in the colonoscopy discussion on codes **45378**-**45393**, **45398**. Note that the structure of the code families are parallel to each other.

45331 *Sigmoidoscopy, flexible; with biopsy, single or multiple*
*(Do not report **45331** in conjunction with **45349** for the same lesion)*

The exclusionary parenthetical note for code **45331** indicates that endoscopic mucosal resection (EMR) includes biopsy of the lesion and, therefore, it (sigmoidoscopy biopsy) should not be reported for the same lesion. However, it may be reported for a separate lesion/site or a different encounter during the same day, if modifier **59** is appended.[6]

45332 *Sigmoidoscopy, flexible; with removal of foreign body(s)*
*(Do not report **45332** in conjunction with **45330**)*
*(If fluoroscopic guidance is performed, use **76000**)*

National Correct Coding Initiative (NCCI) edits preclude the use of code **76000** (fluoroscopic guidance supervision and interpretation) with any endoscopic code, even with modifier **59**, for Medicare.

45333 *Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps*
*(Do not report **45333** in conjunction with **45330**)*

The change in the descriptor language for code **45333** has removed the reference to bipolar cautery, which is just a type of "hot biopsy forceps."[7]

45334 *Sigmoidoscopy, flexible; with control of bleeding, any method*
*(Do not report **45334** in conjunction with **45335, 45350** for the same lesion)*
*(Do not report **45334** in conjunction with **45330**)*

If control of bleeding is performed via submucosal injection of a substance, no separate reporting of the submucosal injection code **45335** would be appropriate for the same lesion. Likewise, if hemorrhoid banding was utilized, control of bleeding code should not be reported separately, and vice versa. As in other GI endoscopy code families, the CPT 2015 revised terminology uses "any method," rather than a list of devices or methods to control bleeding.[8]

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