

ACOG

Committee
on Coding and
Nomenclature

Committee Opinion



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Tubal Ligation with Cesarean Delivery

Tubal ligation at the time of cesarean delivery requires significant additional physician work even though the technical work of the procedure is brief. Informed consent by the patient requires considerably more counseling by the physician regarding potential risks and benefits of this procedure than is necessary with alternative means of sterilization and contraception. Also, many states require completion of special informed consent documents in addition to the customary consent forms required by hospitals. These forms must be completed before scheduling the procedure.

Patients have the right to change their minds. Thus, it is important to reconfirm the patient's decision shortly before the operation.

Tubal ligation with cesarean delivery involves removal of a segment of fallopian tube, which is sent for histologic confirmation. With most cesarean deliveries, tissue is not evaluated by a pathologist. Accordingly, it is important for the surgeon to verify the pathology report, which adds an additional component to post-service work.

The risk of professional liability for operative complications is increased with this procedure. This risk is low, but real. Furthermore, sterilization failure occurs in about 1 in 100 cases even though the operation was performed properly. This failure also carries a liability risk.

Because tubal ligation is a discrete extra service, it should be coded accordingly: 59510 or 59618—routine obstetric care including antepartum care, cesarean delivery, and postpartum care—and 58611—ligation or transection of fallopian tube(s) done at the time of cesarean delivery or intra-abdominal surgery.

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