

OB/GYN Coding & Compliance Quick Reference

A one-page teaser covering global obstetric packages and gynecologic procedure bundling — practical starting points for coders, billers, and providers. This is general education, not a substitute for payer-specific policy or a full audit.

Documentation Musts

- Antepartum visit count tracked accurately against the global OB package definition used by each payer.
- Delivery type (vaginal, C-section, VBAC) and any complications documented distinctly from routine antepartum/postpartum care.
- Transfer-of-care documentation when a patient changes providers mid-pregnancy, so global billing isn't duplicated.
- Medical necessity for ultrasounds tied to specific clinical indications, not routine screening alone, when required by payer policy.

Common Denial Triggers

- Global OB package billed when care was actually split across multiple practices without proper unbundling.
- Antepartum E/M visits billed separately when they should fall inside the global package.
- Gynecologic procedures bundled under NCCI edits billed as separate line items without a valid modifier and documentation.

Modifier Watch-Outs

Modifier 51 (multiple procedures), 59/XU (distinct procedural service) for same-session gynecologic procedures, and correct antepartum-only billing (when care is split) are the areas OB/GYN practices most often get flagged on audit.

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